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DIVISION OF VITAL RECORDS,	
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MARGARET

31. DATE FILED (Month, Day, Year) APR

E. CALLAN, M.D.

32. REGISTRAR'S SIGNATURE

		FOR 1 - STATE REGISTRAR	STATE OF I						MENTAL HYGIEN	_	10001
	1	1. DECEDENT'S NAME (First, Middle, Last)			CERTIF	ICATE	OF DEA	IH	REG. NO 2. DATE OF DEATH MONTH D		3. TIME OF DEATH
	1	CLARA JEAN	SCHUMANI	1					April 12,	1995	8:30 P H
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yr	s. last birthday)	IF UNDER 1		R 24 HRS.	7. DATE OF BIRTH	8.1	BIRTHPLACE (State or Foreign
1		018-22-4853	1 🗆 M 2 💢 F	75	YRS.	MONTHS (AYB HOURS	MIN.	Sept. 10,		ountry) Maryland
	1	9e. FACILITY NAME (If not institution, give st	reet and number)			96. CITY, T	OWN OR LOCAT	ION OF DE		9c. COUNTY	
5	a Section	125 Cody Drive	Unit 24			The	rmont			Time at	
18	1	RESIDENCE OF DECEDENT	0111C 24			1110	LIMOITE			Fred	erick
DIRECTOR	ł	10e. STATE 10b. COUNTY	•		10c. CI1	TY, TOWN OR	LOCATION				10d. INSIDE CITY LIMITS?
=	1	Maryland Fred	lerick		T	hurmor	t				1 XYES 2 NO
A A	ı	10e, STREET AND NUMBER					10f. ZIP COD	Œ		10g. CITIZEN	OF WHAT COUNTRY?
FUNERAL	1	125 Cody Drive	Unit 24				217	88		Unite	d States
5		11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S	ARMED	13. WA	S DECENDENT	OF HISPAN	HC ORIGIN? (Specify Yes		RACE — American Indian.
BY F	1	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1	MR OR DATES	X NO	1 y	YES 2 NO	en, Mexice Specify	n, Puerto Rican, etc.)		Black, White, etc. Specify:
	1	3 Widowed 4 Divorced									White
		15. DECEDENT'S EDUC (Specify only highest grade		184	DECEDENT'S	USUAL OCC	JPATION ing most of worki	ina	16b. KIND OF BUS	SINESS/INDUST	RY /
ш		Elamentary/Secondery (0-12)	College (1-4 or 5	+)	life. Do NOT u	se retired.)				_ /	/ Furniture
2			4		Busil	1655			Fune	rai	, red Mirsa
COMPLET	1	17. FATHER'S NAME (First, Middle, Last)					18. MOT	HER'S NA	ME (First, Middle, Maiden	Sumeme)	
E m		Raymond E. Crea	iger				E	dith	Grace Wil	es	
TO B	I	19e. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS (S	treet end Numbe	or Or Rural F	Route Number, City or Tow	n, State, Zip Coo	le)
밀	1	Robert Schumann	1		125	Cody I	rive U	nit :	24 Thurmo	nt, MD	21788
<u> </u>		20e. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remo	aval from State		ACE AND DATE				DATE 20c. LO	CATION - City	or Town, State
Ē		Donetion 5 Other (Specify)	THE HOLE GLER	BI	ue Rid						, Maryland
<u> </u>	ı	21. SIGNATURE OF FUNERAL SERVICE LIG	eyisee 0			22. NA	ME AND ADDRE	SS OF FA	CILITY Stauffe	r Fune	cal Homes, F
examiner must be notified at once. TO BE COM	ı	None of	Non	an		104	East M	ain :		urmont	
	┪	23 PART I. Enter the diseases, or c		X	- dth D-						
шедіса	1	shock, or heart failure. I	List only one cal	se on aach	line.	not antar th	e moda or dy	ring, suci	h aa cardlac or reapi	retory arreat,	Approximate Interval Between
9	U	iMMEDIATE CAUSE (Final disease or condition							-		Onaet and Death
event,	k	reauiting in death)	ACU7	EC	DNG	55771	E HE	-HIZ	ア トカル	UZE	1/2-1 HTZ
. 8	1	disease or condition resulting in death) a. ACUTE CONCESTIVE HEATET FRILUTE 1/2-1 HR DUE TO (OR AS A CONSEQUENCE OF):									
RTIFICATION	ı	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF):									
ATI	ŀ	any, taking to minimutate									
TIFIC	ı	CAUSE (Disease or Injury	DUE TO	OR AS A COL	NSEQUENCE O	14	FOR	60	SIDIV		15 YEARS
	I	that initiated evants reaulting in death) LAST		(011 A0 A 001	NOLUULINUL U	· ,.					
Injury, or	-		1								
		PART II. Other significant condition	contributing to	death but n	ot reauiting	in the unda	rlying causa	givan in			24b, WERE AUTOPSY FINDINGS
MEDICA	ı								PERFOR	/-	AVAILABLE PRIOR TO COMPLETION DF CAUSE
: MEDIC	1									Z NO	OF DEATH?
E .		DID TOBACCO USE CONTR	BUTE TO CA	USE OF D	DEATH Y	ES IZ NO	D IINO	CERTAIN			1 TES 2 NO
A S	H	25. WAS CASE REFERRED TO MEDICAL	COLE TO CA		PLACE OF DEA			LKIAII			
E	- 14	EXAMINER?	HOSPITAL:			OTHER:		, , ,	6 C Other (Specify)		
SICI	1	27. MANNER OF DEATH	26e, DATE OF	INJURY	26b. TIN		c. INJURY AT	esidence	26d. DESCRIBE HOW II	N IIIBY OCCUPE	:n
HYSICI				ay, Year)		JURY	WORK?	¬ NO	200. DESCRIBE HOW I	NJORY OCCURE	
5 ≥		1 Natural 5 Pending	(Month, D								
B Z		1 Natural 5 Pending 2 Accident Investigation		F INJURY — A	At home, farm.				284 LOCATION (Street	and Mumber on E	cont Bouts Months
B Z		1 Natural 5 Pending	28e. PLACE O	F INJURY — A	At home, ferm,				281. LOCATION (Street & City or Town, State)	and Number or R	ural Route Number,
Z8 IS Man	1	1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined	28e. PLACE O building,	atc. (Specify)		atreet, factory	office		City or Town, State)		ural Routa Number,
Z8 IS Man		1 Netural 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be determined	28e. PLACE O building,	my knowledge	e, death occurr	atreet, factory	office	e, end due	City or Town, State) fo the cause(s) end mer	iner ee atated.	
Z8 IS Man		1 Natural 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER	28e. PLACE O building,	my knowledge	e, death occurr	atreet, factory	office	e, end due	City or Town, State) fo the cause(s) end mer	iner ee atated.	ural Routa Number, use(e) and manner se stated.
E COMPLETED BY		1 Netural 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be determined	28e. PLACE O building,	my knowledge	e, death occurr	atreet, factory	, date end place	e, end due red at the	City or Town, State) fo the cause(s) end mer time, date end place, en	iner ee atated.	
COMPLETED BY		1 Natural 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER	28e. PLACE O building,	my knowledge xemination enc	e, death occurr	atreet, factory and at the time on, in my opin	, date end place	e, end due red at the	City or Town, State) fo the cause(s) end mer time, date end place, en	iner ee atated.	use(e) and manner se stated.

14 W. MAIN ST.

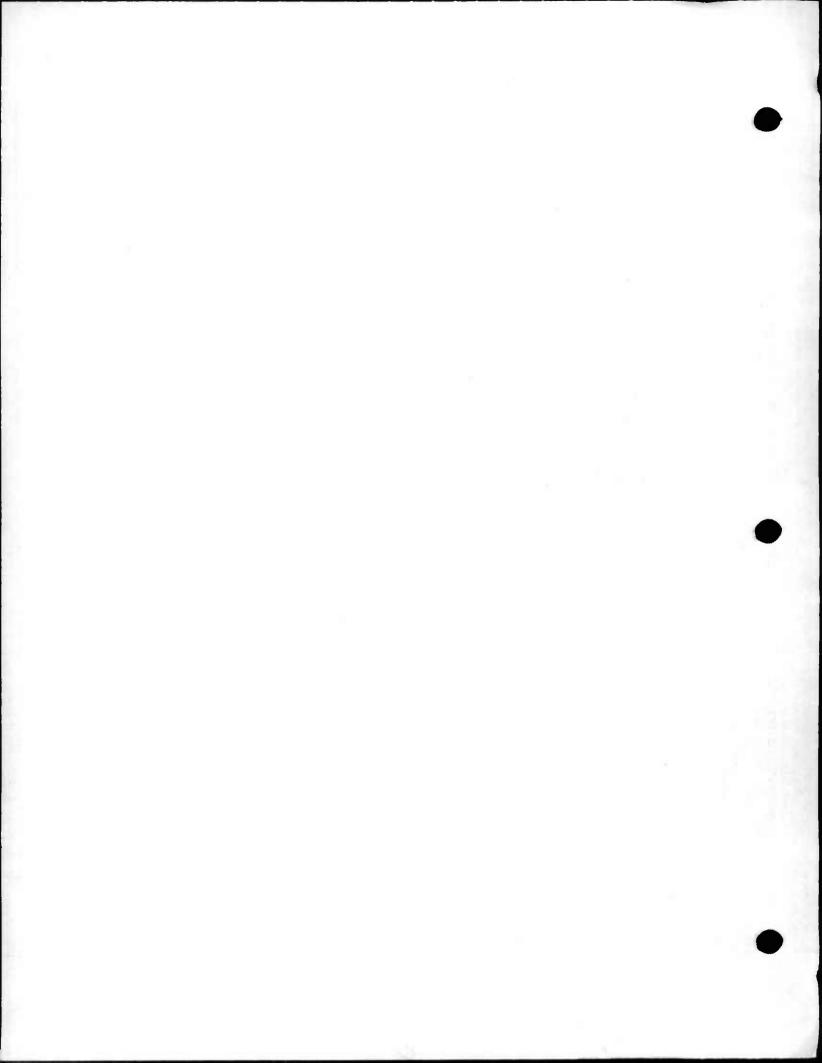
THURMOUT, MA, 21788

an. transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY FUN	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
e funeral director, page 5 should be detached for use as the burial-tral.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trope filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
r death. Page 6 may be retained by the hospital or attending physicia	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a flour after death. Page 6 may be retained by the hospital or attending physicia

	200											9)	13002
	1 - STATE REGISTRAR		STATE OF I	MARYLAND	DEPAI	RTMEN	T OF H	IEALTH DE A	AND	MENT/		Ε		
ş	1. DECEDENT'S NAME (First	, Middle, Last)			LITTI	ICAI	LOI	DEA		2. DAT	REG. NO.			3. TIME OF DEATH
1 8	Ruth E1	.1en	Stup							MON	pril 12		YEAR	8:40 A M
	4. SOCIAL SECURITY NUMBER 218-50-3477		5. SEX	8. AGE (In yrs. In 95	est birthday) YRS.	IF UNDE	DAYS	IF UNDE	R 24 HRS. MIN.	7 DAT	e of BIRTH		8. BIRTH	HPLACE (State or Foreign
	9e. FACILITY NAME (If not in					9b. CIT	Y, TOWN (OR LOCATI	ON OF DE		7,51		NTY OF D	-
DIRECTOR	Frederick		rial Hosp	ital			ede					F	rede	erick
E	10a. STATE	10b. COUNT				Y, TOWN		TION						10d. INSIDE CITY LIMITS?
	Maryland		lerick		Fı	ceder	ick							1 X YES 2 NO
FUNERAL	100. STREET AND NUMBER 2 James		et Apt.	1B			101	21701	€ .			10g. CITI	S.A	WHAT COUNTRY?
E	11. MARITAL STATUS 1 Never Married 2		12. WAS DECEDEN FORCES? 1	T EVER IN U.S.A.	RMED	13.	WAS DEC	ENDENT (OF HISPAN	NIC ORIG	IN? (Specify Yea Ricen, etc.)	or No—	14. RACE	E — American Indian, k, White, etc.
ВУ	3 Widowed 4 Divo		IF YES, GIVE Y	AR OR DATES	,,,,,			2 X NO	Specif		riicen, etc.)		Speci	the:
	15. DEC	EDENT'S EDU	CATION	16e. D	ECEDENT'S	USUAL O	CCUPATIO	ON.			b. KIND OF BUS	MIESE IIII	MINTEN	White
ET	(Specify onl	y highest grade	College (1-4 or 5	(i	Give kind of e. Do NOT u	work done se retired.)	during mo	st of workli	ng	"	o. KIND OF BUS	IINE99/IND	JUSTHY	
COMPLETED	8				Н	omema	ker				Own I	Home		
	17. FATHER'S NAME (First, M George			CLAY				18. MOT	HER'S NA		Middle, Maiden		UNG	
BE	194. INFORMANT'S NAME (1				20.000.000									
2	Vernon E.	Stup			5822	Butt	erf	Ly La	ane,	Fre	nber City or Town derick	, State, Zip Mar	ylar	nd 21702
	20a METHOD OF DISPOSIT	iON on 3 □ Remo	ovel from State	20b. PLACE cemetery, cr	AND DATE	OF DISPOS	SITION (Na	me of		DA	TE 20c. LO	CATION —		
	4 Donation 5 Other 21. SIGNATURE OF FUNERA		CENSEE	cemetery, cr Moun	t Oliv	et Ce	meter	y, Ap	ril l	5, 19	195 Fre	ederi	.ck,	Maryland
	▶ Richar	36	Grad	MOO	255	I K	06 I	ey ar East	id Ba	esfo cch	rd P.A.	Fun	eral	Home Md. 21701
	23. PART I. Enter the d	iseases, Dr o	omplications the	t ceused the d	eeth. Dp (not enter	the mo	de of dy	ing, suc	h as ce	rdiac or reapi	ratory srr	eat,	Approximate
	IMMEDIATE CAUSE (Fir		List only Dre ceu	se on eech iin	е.									interval Between Onset and Death
	disesse or condition	→	. Str	oke			_	_						14
			DUE TO	OR AS A CONSE	QUENCE O	F):								/
CERTIFICATION	Sequentially list condition in any, leading to imme-	ione,	bDUE TO	(OR AS A CONSE	OUENCE O	F):								
S	cause. Enter UNDERLY	NG	C											
	thet initieted eventa reaulting in death) LAS		DUE TO	(OR AS A CONSE	QUENCE O	F):						-		
E	- Casting in addition and		d											
-	PART II. Other algolitica	nt condition	a contributing to	deeth but not	resulting	in the ur	nderlying	ceuse (given in	Part i.	24a, WAS AN		24b.	WERE AUTOPSY FINDINGS
MEDICA		- 10									PERFOR	. /		AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME								/_		_				1 TES 2 NO
N.	DID TOBACCO U		RIBUTE TO CA					UNC	ERTAIN	4 <u></u>				
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:		CE OF DEA	OTHEI								
HYS	1 YES 2 NO		1 I Inpetient 2 28a. DATE OF		28b. TIM		sing Hom- 28c, INJ		sidence		er (Specify)			
	1 Netural 5	Pending	(Month, D		IN.	URY M	WO	RK?	NO	28d. DE	SCRIBE HOW IN	JURY OCC	URED	
D BY	• 🗆 •	Could not be	28e. PLACE O	F INJURY — At he	ome, farm,	street, fact			7 12	281. LO	CATION (Street e	nd Number	or Rurel R	loute Number,
COMPLETED		determined	bullding,	etc. (Specify)						City	or Town, State)			
PLE	29e. CERTIFIER (Check only	IFYING PHYSIC	CIAN: To the best of	my knowledge, d	eath occurr	ed at the t	lme, date	end place.	end due	to the ce	use(e) end men	ner ee state	ed.	
Ö) end manner ee stated.
BE C	29b. SIGNATURE AND TITLE	OF CERTIFIER						29c. LICE	NSE NUM	IBER		29d. DATE	SIGNED	(Month, Day, Year)
10	710 100							D 3	5322	2		•	4/1	2/95
	Dr. Konrad		kker 80	1 To11	House		F	rede	rick	c. Ma	arvland	217	01	
	31. DATE FILED (Month, Day,	Year)	32. REGISTRA	SIGNATURE	0		, _			,				
	APR 1	7 1995	Javao	undian !	artal									



ttending physician. BALTIMORE. MARYLAND 21215-0020

Pages 1, 2, 3 should

permit.

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or a	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for us be filled within 72 hours after death with the State Deut of Health and Mental Hoviden notor to build cremation or removed.	IMPORTANT: if Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: T	TO THE FUNERAL DIRECTOR: After this certificate be filed within 72 hours after death with the State	IMPORTANT: If item 28 is marked, or ite

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AND ADDRESS OF PERSON

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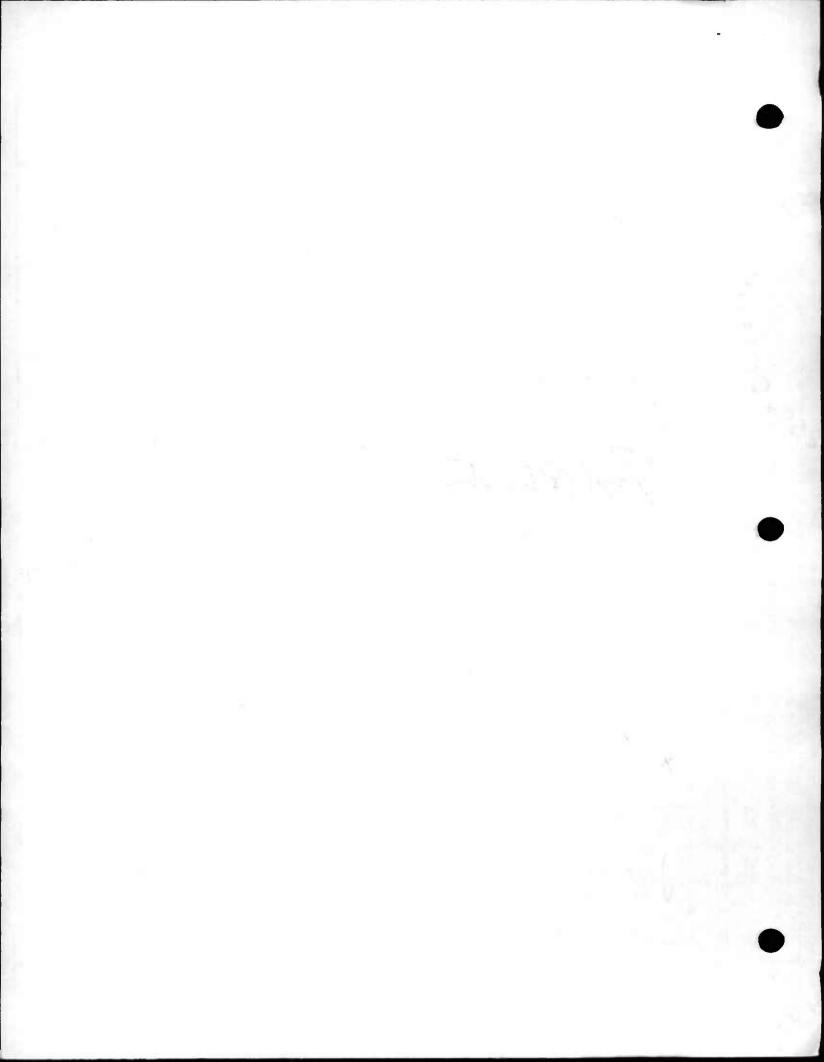
PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3 TIME OF DEATH Willie 7. DATE OF BIRTH

(Month, Day Year)

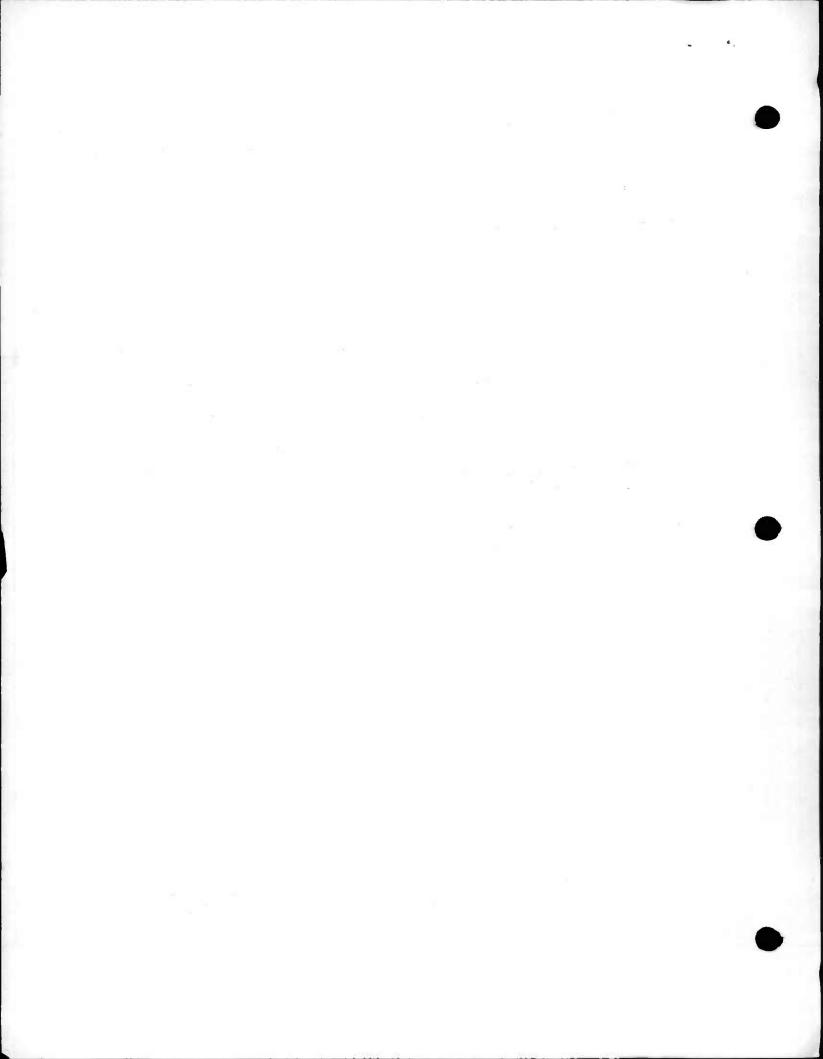
JULY 10, Scaggs 0400 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign 1)0 1 2 | F 577-22-2221 DAYS HOURS 71 Washington DC 1923 9s. FACILITY NAME (If not institution, give street and number) 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Washington Adventist Hospital DIRECTOR Takoma Park Montgomery RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's District Heights 1 TYES 2 X NO FUNERAL 10a STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 7108 Gateway Blvd. 20747 United States 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-il yes, specify, Cuben, Maxican, Puerto Ricen, atc.) 1 YES 2 ZANO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2XX Married 1943-1946 BY 3 Widowed 4 Divorced White 18a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16b. KIND OF BUSINESS/INDUSTRY intary/Seconda ndary (0-12) College (1-4 or 5+) Plant Manager Laundry Company 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Grover S. Scaggs Rose Gertrude Samuels BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Mary Lou Scaggs 7108 Gateway Blvd., District Heights, Md 20747 pe 20a METHOD OF DISPOSITION
142 Burlal 2 Cremellon 3 Rem 20b. PLACE AND DATE OF DISPOSITION (Name of April 20 plig 520c. LOCATION - City of Town, State must Gate of Heaven Cemetery Silver Spring, Maryland 4 Donation 5 Other (Specify) examiner 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 6633 Old Alexander Ferry Road, Clinton, Md 20735 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition_ DUE TO event, t reaulting in death) hours other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST injury, or PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE PERFORMED? 1 TYES 2 DINO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER 1 YES 2V NO Inpatient 2 - ER/Outpetient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Yeer) 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident 5 Pending BY 1 YES 2 NO 28e. PLACE OF INJURY — Al home, term, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide determined 29e. CERTIFIER 1 🔁 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(e) end manner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospit	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remonal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
within 24 hours after death. Page	spletely filled in by the funeral d cremation, or removal.	rent, the medical examiner
death certificate be executed	ne attending physician and com Mental Hygiene prior to burial,	ury, or other traumatic ev
IAN: The law requires that the	tificate has been signed by the State Dept. of Health and N	or item 23 shows any inj
TAL OR ATTENDING PHYSIC	AL DIRECTOR: After this cer 72 hours after death with th	If item 28 is marked, o
TO THE HOSP!	TO THE FUNEI be filed within	IMPORTANT:

	1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF H			HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)		hields	,III	/	2 DATE OF MONTH	DEATH DAY 199	S YEAR	3. TIME OF DEATH 8/9 M
		X M 2 🗆 F	15 YRS.	IF UNDER 1 YEAR			1,1950	NEW	YORK
CTOR	SOUTHERN MARYLAND I				INTON	EATH		RINCE	GEORGE
- DIRECTOR		GEORGE		DEN DEN	ION				10d, INSIDE CITY LIMITS? 1 YES 2 X NO
VERAI	16525 BALD EAGLE SO	CHOOL ROAD			20613		U	S.A.	HAT COUNTRY?
BY FUNERAL	1 Never Married 2 Y Married	WAS DECEDENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR DA	2 NO	If yes, sp	endent of Hispan ecify Cuben, Mexice 2 NO Specify	n, Puarto Rice	Specify Yea or No— an, atc.)	14. RACE Black, Specify	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade composition of the composition of th		16e, DECEDENT'S U: (Give kind of wo life. Do NOT use	rk done during mo		16b, Kil	ND OF BUSINESS/IN		16
MPL			FIREFIGHT	TER/PAR	AMEDIC	FI	RE DEPAR	TMENT	
	17. FATHER'S NAME (First, Middle, Last) JAMES JOSEPH SHIELE	qr. 20			16. MOTHER'S NAI		de, Maiden Surname)		
) BE	19e. INFORMANT'S NAME (Type/Print)	73, UK.	19b. MAILING A	DDRESS (Street e			City or Town, State, Zi	ip Gode)	
5	MARY E. SHIELDS						BADEN, I		613
	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal 4 Donation 5 Query	from Ctota	BY L'AND OF ST			DATE // 17	20c. LOCATION -		
	21. SIGNATURE OF PUNERAL SERVICE LICENSE		PILAND VI	22. NAME AN	D ADDRESS OF FAC	CILITY		11/4115	MARTLAND
	BENJAMIN M. MAT	THEWS M-0	00658	P.O. I	UNTT FUNI BOX 156 V	eral h Wai dor	OME,INC. F, MARYL	AND	20604
Z	23. PART I. Enter the diseases, or compshock, or heart feilure. Liet IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Sessures	the deeth. DD nD ch line. disorde- consequence of:	/	de of dylng, such	h as cerdiad	or respiratory ar	rest,	Approximate interval Between Onset and Dasth
CERTIFICATION	Sequentielly liet conditions, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):						
MEDICAL	PART II. Other eignificant conditione co	ntributing to deeth bu	it not reeulting in	the underlying	g ceuee given in		PERFORMED? YES 2 NO		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
N.	DID TOBACCO USE CONTRIBL				UNCERTAIN	1 🗆			
PHYSICIAN:		SPITAL:		THER:	-17				
ΉΫ́	27, MANNER OF DEATH	200. DATE OF INJURY	28b. TIME	OF 26c. INJ	S Residence		Decify) IBE HOW INJURY OC	CURED	
BY	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUF	M 1 🗆 Y	ES 2 NO				
8	3 Suicide 8 Could not ba 4 Homicide detarmined	28a. PLACE OF INJURY building, atc. (Special Control of the Contro	— At home, tarm, atro	et, factory, office		28t, LOCATIO	ON (Street end Number own, State)	r or Rural Ro	ute Number,
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: 2 MEDICAL EXAMINER: On	To the beat of my knowle the basic of examination	edga, death occurred and/or investigation,	at the time, data in my opinion, de	and place, and due	to the cause(a) and manner as sta I place, end due to t	ted. he ceuse(s)	and menner as stated.
H	29b. SIGNATURE AND TITLE OF CERTIFIER	rang M?			29c LICENSE NUM 2/2	IBER	29d, DAT	E SIGNED	Month, Day, Year)
TO.	30 NAME AND ADDRESS OF PERSON WHO CO	VIBULZ/	TH (ITEM 27) (Type, P.	og Ra	ychum (14. C.	John I	11/2	-0748
	APR 1 8 1995	32. RESTRARES SIGNA	TURE Randall		1			-	



FOR STATE REGISTRAR

579125207

4. SOCIAL SECURITY NUMBER

DECEDENT'S NAME (First, Middle, Last,

WILLIAM F. TYKOCINSKY

9s. FACILITY NAME (If not institution, give street and number

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Pages 1, 2, 3 should DIRECTOR Perry Point VA Medical Center Perry Point, Md. RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION **MARYLAND** CECIL PERRY POINT permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE the burial-transit 21902 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-1 X Never Married 2 Married If yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1 YES 2 X NO Specify B 3 Widowed 4 Divorced WW II 16e. DECEDENT'S USUAL OCCUPATION use as ED 15. DECEDENT'S EDUCATION (Specify only highest g (Give kind of work done life. Do NOT use retired.) Щ P Elementary/Secondary (0-12) College (1-4 or 5+) 12 COMPL MILITARY POLICE page 5 should be detached 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) BORUCK TYKOCINSKI notified at GERTRUDE BRANSPIEGEL BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 STANLEY OSTROW 14117 NORTH GATE DRIVE-SILVER SPRING, MD. 20906 pe 20s. METHOD OF DISPOSITION
1X Buriel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of must DATE funeral director, cemetery, cremetory or other place)
MT. LEBANON CEMETERY 4/7 examiner 21. SIGNATURE OF TUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. Hanh 1170 ROCKVILLE PIKE-ROCKVILLE, MD. 20852 the the medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, in and completely filled in by it to burial, cremation, or remoshock, or heart fellure. List pnly one ceuse on each line IMMEDIATE CAUSE (Final disease or condition resulting in desth) Excerbation Chronic Obstructive Pulmonary Disease event. DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentistiv list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate attending physician prior cause. Enter UNDERLYING CAUSE (Diseese or injury / the attending physique p other thet initieted events DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST 6 PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. MEDICAL Health and I shows any t. of F DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) item certificate to the State NOSPITAL:
14 Inpatient 2 ER/Outpatient 3 OTHER: 1 TYES 2 T NO 4 Nursing Home 5 Residence 6 Other (Specify) DOA 10 27. MANNER OF DEATH 28s. DATE OF INJURY 26c. INJURY AT marked, this c 5 Pending Investigation Natural 1 YES 2 NO ΒY After 2 Accident 26s. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) TO THE HOSPITAL OR ATTENDING TO THE FUNERAL DIRECTOR: At the filed within 72 hours after de IMPORTANT: If item 28 is in 3 Sulcide 10 ETED. 6 Could not be 4 Homicide determined 29e. CERTIFIER COMPL 1 XCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the films, data and placs, and dus to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE D38687 424 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stephen Katz, M.D., Perry Point VA Medical Center, Perry Point, Md., 21902 32 DEGISTRAR'S OGNATUR

CERTIFICATE OF DEATH

IF UNDER 1 YEAR

IF UNDER 24 HRS

9b. CITY, TOWN OR LOCATION OF DEATH

6. AGE (In vrs. last birthday

74

MONTH 4

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95 13005 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO 2. DATE OF DEATH 3. TIME OF DEATH 95 10:30P 7. DATE OF BIRTH 8. BIRTHPLACE (State or Forming oth, Day, 28 Poland 20 9c. COUNTY OF DEATH 21902 Cecil 10d. INSIDE CITY 1 X YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES 14. RACE — American Indian, Black, Whits, stc. WHITE 16b. KIND OF BUSINESS/INDUSTRY U.S. GOVERNMENT 20c. LOCATION — City or Town, State ADELPHI, MARYLAND Interval Between Onset and Death 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINGINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? PERFORMED? 1 TYES 2 T NO 1 YES 2 NO 26d. DEŞCRIBE HOW INJURY OCCUREO 261. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29d. DATE SIGNED (Month, Day, Year)

▶ 4/5/95

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burial-transit permit. Pages 1, 2, 3 should

for use as the

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page 5 should

funeral director,

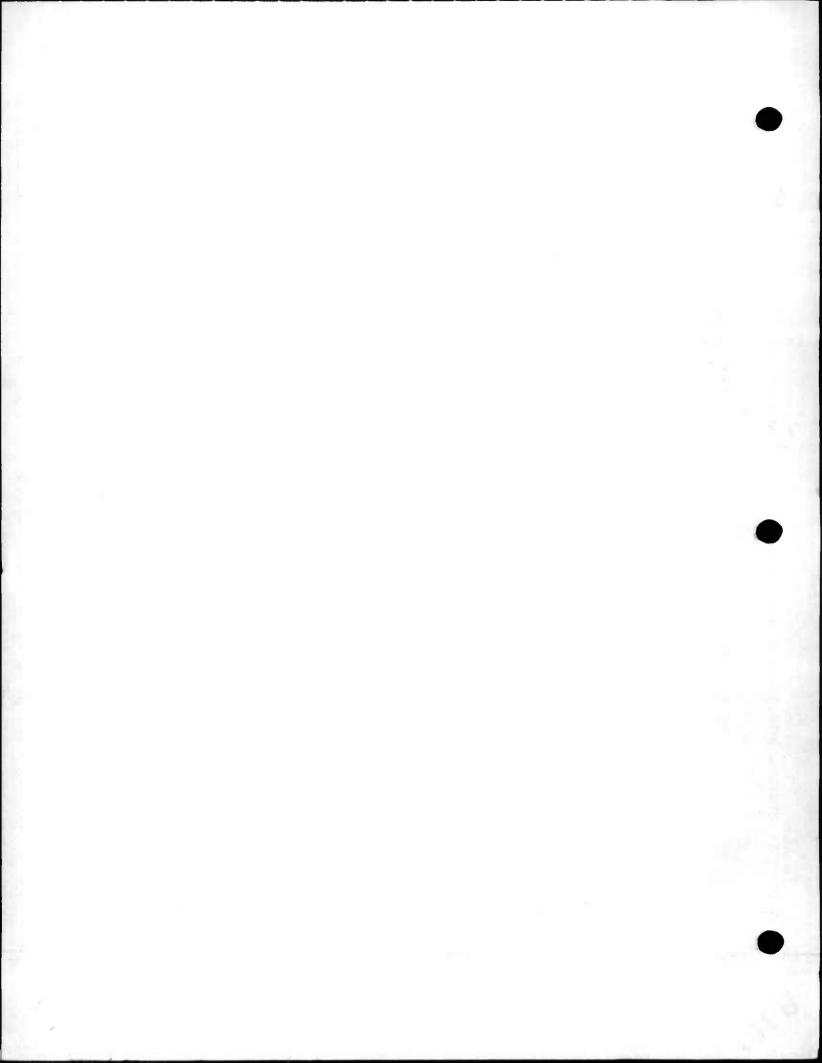
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	2 THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within	D THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely if fied within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremar
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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH AOPe AN ERRI 12:19pm William 1995 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTN (Month, Day, Year) 6. AGE (In vrs. last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign DAYS 216-74-5074 1 M 2 | F 26 Jan. 1969 Florida 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR Suburban Hospital Bethesda Montgomery 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY West Wood Williamstown 1 X YES 2 | NO Virginia FUNERAL 10f ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 801 Huggins Road 26187 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 YNO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indien, Black, White, alc. 1 Never Married 2 Married 2 XNO specify Cuban, Maxican, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES 1 TYES 2 TO NO B Specific 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b, KIND OF BUSINESS/INDUSTRY ring most of working (Give kind of work done ife, Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) Office Manager Retail/Sales once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) notified at BE John H. Terry Wendy Coteler 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 26187 Wendy Rose Huggins Road, Williamstown, West Virginia be 20a. METNOD OF DISPOSITION 20b. PLACE AND DATE of Disposition (Name of competery, crematory or other place) appril 12, 1995 Mid-Ohio Valley Cremation Service Parkersburg, WV must 1 Buriel 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) examiner 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 21. SIONATURE OF FUNERAL SERVICE LICENTIA M00803 Wisconsin Avenue, Bethesda, Maryland medical 23. PART I. Enter the diseases, or complications that devaed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or haart failure. Liet only one cause Interval Between IMMEDIATE CAUSE (Finel **Onaet and Death** other traumatic event, the disesse or condition 10rd a 2/01 resulting in death) neton CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE if any, leading to immediate cause. Enter UNDERLYING Ku in CAUSE (Disesse or injury AS A CONSEQUENCE OF that initisted events resulting in death) LAST 0 injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AWAILABLE PRIOR TO shows any COMPLETION OF CAUSE DF DEATH? 1 TES 2XXNO t TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item HOSPITAL: OTHER: 1 X YES 2 NO 1 1 Inpatient 2 ER/Oulpatie 4 Nursing Nome 5 Realdence 6 Other (Specify) 10 27. MANNER OF DEATH 28a. DATE OF INJURY 28c. INJURY AT WORK? 26d. DEŞCRIBE HOW INJURY OCCURED marked. 1 Natural 5 Pending BY 1 YES 2 NO 2 Accident
3 Suicide Investigation 26a. PLACE OF INJURY — Al home, ferm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, 28 is COMPLETED 8 Could not be 4 Homicide Hem 29e. CERTIFIER 1 XXCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the Ilms, date and place, and due to the cause(a) and manner ea stated. (Check only one) TO THE HOSPITAL
TO THE FUNERAL
DE filed within 72 h
IMPORTANT: If it 2 MEDICAL EXAMINER: On the ation end/or investigation, in my opinion, death occured at the time, data and placa, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIE 29d. DATE SIGNED (Month, Day, Year) BE 29c. LICENSE NUMBER mp 2 30. NAME AND ADDRESS OF PERSON WHO MPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. 10215 Fernwood Road, #504, Bethesda, MD Vincente M.D. 20817-1106 Gázman, 32. HEGISTHAR'S SPARTING 31. DATE FILED (Month, Day, Year) APR 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	1. OECEDENT'S NAME (First, Middle, Last)				4			2. DATE OF G	DEATH			. TIME OF DEATH	
	Martin	I		-	Thora	20		Ann				425 P	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. A	AGE (In yrs. lest	birthday)	IF UNDER 1 Y	EAR	IF UNDER 24 HRS.	7. DATE OF B	HRTH		8. BIRTHPL	ACE (State or Foreign	
	141-20-7114	1 M M 2 □ F	67	YRS.	MONTHS D	MYS	HOURS MIN.	April	19,]	L927		Jersev	
	9e. FACILITY NAME (If not institution, give	street end number)			9b. CITY, TO	OWN O	R LOCATION OF D						
OR	Shady Grove Adve	ntist Hospi	ital			Ro	ockville		- 1				
5	RESIDENCE OF DECEDENT	norde noopi	LCUI			110	JONVIII				110111	egomery	
R	1 10e. STATE 10b. COUNT	Y		10c. CIT	Y, TOWN OR L	LOCATI	ION				10		
DIR		ontgomery		_		Ro	ockville				1		
M	10e. STREET AND NUMBER					101.	ZIP CODE			10g. CITIZ	EN OF WH	AT COUNTRY?	
FUNERAL	13705 Lionel Lane						20853			Unit	ed St	tates	
5	11. MARITAL STATUS	12. WAS DECEOENT EV			13. WAS	S DECE	ENDENT OF HISPA	NIC ORIGIN? (S;	pecify Yes	or No-	14. RACE -	- American Indian,	
BYF	1 Never Married 2 Merried	FORCES? 1 X 1)	It ye	YES	city Cuben, Mexico 2 X NO Specif	on, Puerto Rican	i, etc.)			White, etc.	
	3 📉 Widowed 4 🗌 Divorced	World War	II/Ko	rea								White	
OB .	15. DECEDENT'S EDU (Specify only highest grade		18e. DEC	EDENT'S	USUAL OCCU	JPATIO	N at all working	16b. KIN	D OF BUSI	NESS/INDU	STRY		
Щ	Elementary/Secondary (0-12)	College (1-4 or 5+)	life, L	Do NOT us	retired.)				TAL HYGIENE REG. NO. NITE OF OEATH WITH DAY DAY 19 19 19 19 27 S. BIRTHPLACE (State or Foreign Country) New Jersey Sc. COUNTY OF DEATH MONTGOMERY 10g. CITIZEN OF WHAT COUNTRY? United States GIN7 (Specify Yea or No- 10 Rican, etc.) 10 H. RACE — American Indian, Black, White, etc. Specify: White 15b. KIND OF BUSINESS/INDUSTRY US GOVERNMENT White 15t. Middle, Meiden Surmeme) Marie Miersch 10 Linmber, City or Town, State, Zip Code) 11 iamsport, MD 20795 ATE 20c. LOCATION — City or Town, State Silver Spring, Maryland Robert A. Pumphrey Funeral Inc., 300 W. Montgomery Ave and 20850-2805 erdiec or reepiratory arrest, Approximate Interval Between Onest and Death 2 DAYS AMONTG LINE PROPRIES APPROXIMATE APPROXIMATE APPROXIMATE Interval Between Onest and Death 2 DAYS AMONTG LINE PRIOR TO CAUSE DE DEATH? 1 YES 2 NO AND CAUSE DE DEATH? 1 YES 2 NO AND CAUSE DE DEATH? 1 YES 2 NO AND CAUSE DE DEATH? 1 YES 2 NO				
M		4	Ele	ectr:	ical E	ingi	ineer	US	US Government				
Ö	17. FATHER'S NAME (First, Middle, Last)					Т	18. MOTHER'S NA	ME (First, Middle	, Meiden S	umame)			
ш	Peter Jo	seph Thorpe	9				Gla	dys Ma	rie N	4iers	ch		
TO BE COMPLET	Peter Joseph Thorpe Gladys Marie Miersc 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Bural Route Number, City or Town, State, Zip Co								Code)				
Ĕ	19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Timothy P. Thorpe 15444 Dellinger Road, Williamsport, MD 20795									795			
	20e. METHOD OF DISPOSITION 1 A Burtel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Namper) 1 A Burtel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Namper)												
	Gate of Heaven Cemetery Silver Spring, Maryland												
	21. SIGNATURE-OF FUNERAL SERVICE LI	CENSEE	oute c	/1 110	22. NAR	ME ANI	D ADDRESS OF FA	CILITY ROD	ort 7	Dir	mphre	Taryian	
		202	_		Hom	ne/I	Rockvill	e, Inc	., 30	oo w.	Mont	gomery A	
	" medile	- Julia		348	Roc	:kvi	ille, Ma	ryland	208	350-2	805		
	23. PART I. Enter the diseases, or ahock, or heart fellure.	complications that cau List only one cause o	used the dae	th. Do n	ot antar the	e mod	ie of dying, suc	h ae cerdiec	or reepira	story arre	st,		
	IMMEDIATE CAUSE (Final	4											
	disease or condition resulting in death)	. ACUTE	RENI	46	FAIL	4	RE					13 DAYS	
		OUE TO (OR	AS A CONSEOL	JENCE OF	ŋ:								
z I	Comment of the Commen	· ACUTE TO	umor	LYS	K 5	YN	DROME	_				SXNAS	
RTIFICATION	Sequentially list conditions, if any, leading to immediate	OUE TO (OR	AS A CONSEOU	JENCE OF	7):								
<u> </u>	CAUSE (Disease or injury	mp	PEROMA							MONTH			
<u> </u>	that initiated events	DUE TO (OR A	AS A CONSEOU	ISEQUENCE OF):									
	resulting in death) LAST	d											
<u> </u>	PART II. Other significant condition	as contributing to deal	th but not so	autile - 1	n the male	el el e e		0 11 .			7		
MEDICAL	William Symmouth Sorialion	- continuating to deal	in but not le	eulling i	n the Ungar	riying	cause given in	Part I. 24s.			AV	AILABLE PRIOR TO	
ا ۃ								10	YES 2	(NO			
M										`	1	YES 2 NO	
ä	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEAT	H YE	S I NO	A	UNCERTAIL	V 🗆					
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE	OF DEAT	H (Check only	one)						-	
Si.	1 TES 2 NO	HOSPITAL:	Outpatient 3	DOA	OTHER:	Home	5 Residence	8 Other (So	ncify)	-			
PHY	27. MANNER OF OEATH	280. DATE OF INJU		28b. TIM	E OF 280	c. INJU	IRY AT			JURY OCCL	IRED		
BY	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Ye.		INJ		WOR	ES 2 NO						
0 8	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJ	URY — At hom	e, farm, a	treet, factory,	office		281. LOCATION	N (Street an	d Number o	r Rural Rout	e Number,	
	4 Homicide determined	building, etc. (эреспу)					City or Tov	vn, State)				
u /	29e. CERTIFIER	POLANI, To an analysis of the	000,0,033,000		- Cittes	7.10	on the sound	5 = 3 10	0				
MP	(Check only CERTIFYING PHYS												
5		n. On the besis of examin	and/or.lm	restigation	n, in my opini	lon, de	ath occured at the	time, date end	place, end	due to the	cause(e) er	nd manner ee stated.	
ш	294 MENATURE AND TITLE OF CERTIFIE	3	1				29c. LICENSE NUI	IBER		29d. DATE	SIGNED (M	onth, Day, Year)	
∞	James 4.18	Zoevy MI	LAN				D072	181		MAR	IL OF	7 1995	

31. DATE FILED (Month, Day, Year)

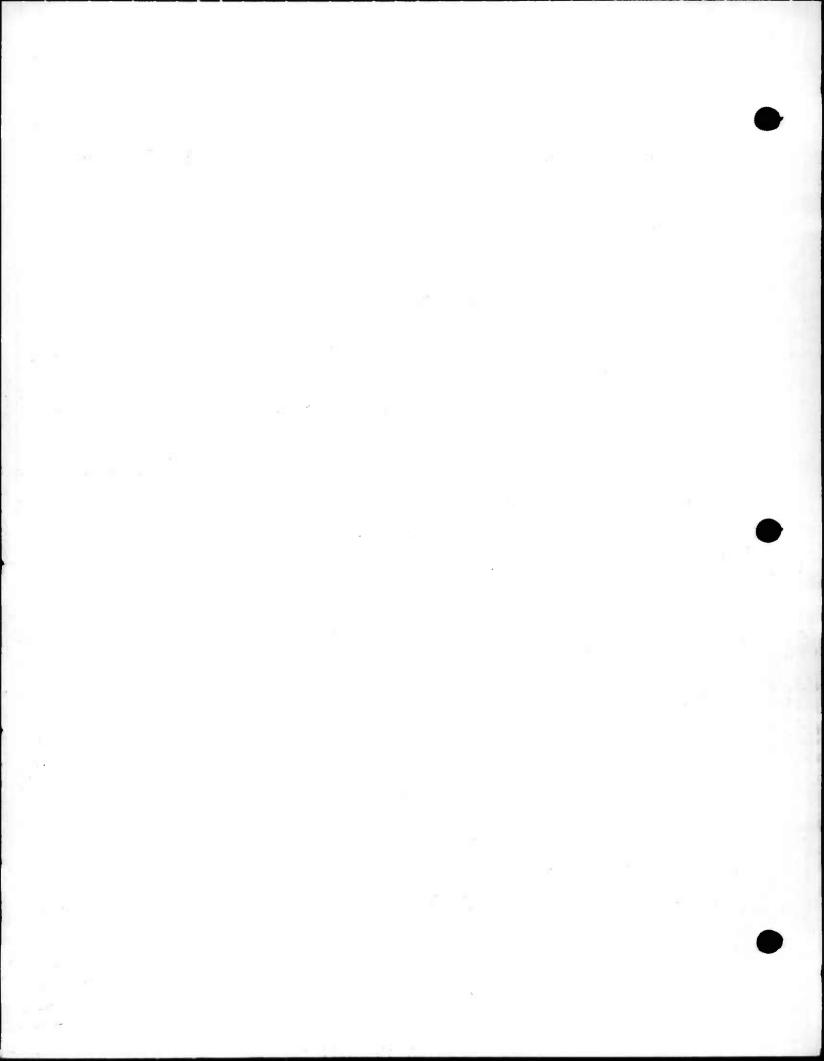
APR 10 1995

JULY STREET CAUSE OF DEATH-TIEM 27) (Type, Print)

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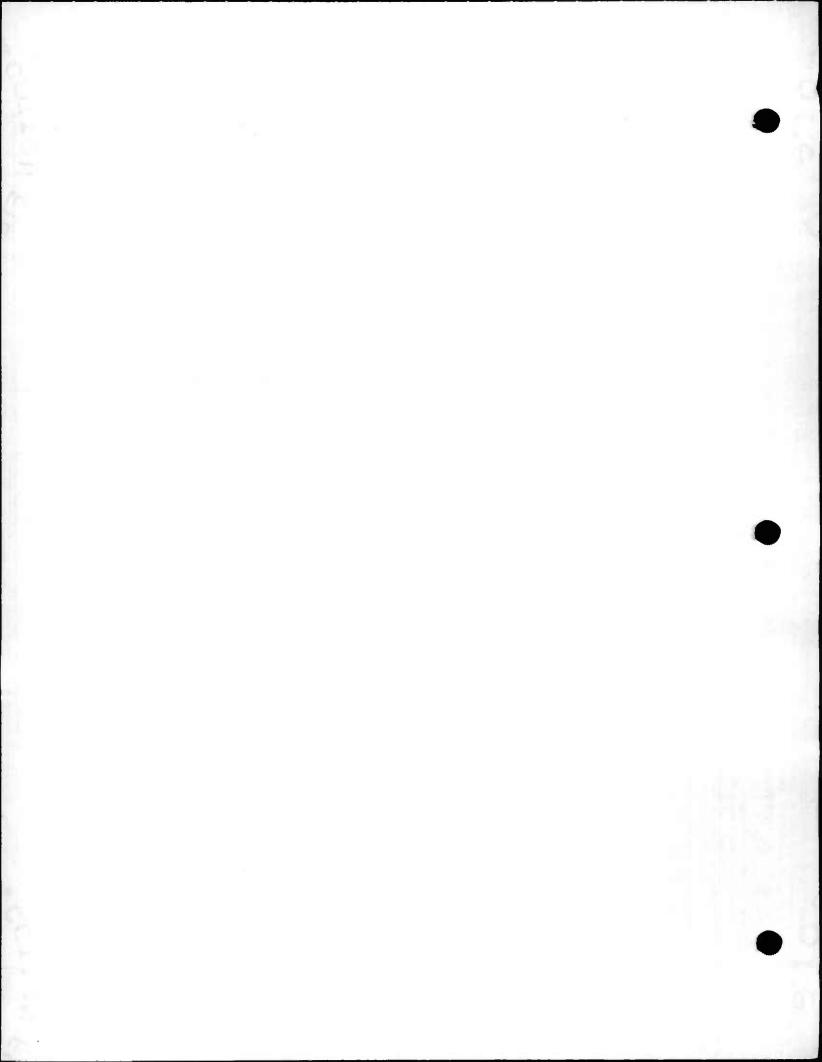
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	A DECEMBER WAS STATED AND STATED		CE	HILL	AIE C	F DEATH	_	REG. NO).		
	1. DECEDENT'S NAME (First, Middle, Last) Va 4. SOCIAL SECURITY NUMBER	5. SEX 4.	Tr	uch.	ans	7	HANNI 8, 1995 1:5				3. TIME OF DEATH
	579-32-1108	1 M 2 XF	AGE (In yrs. lest	77	THE DAY	R IF UNDER 24 HR	S. 7. DAT	E OF BIRTH And the Paris	1000		PLACE (State or Forei
	9e. FACILITY NAME (If not institution, give s	12					ie II,	1922 Florida			
Œ	713 Sheridan Str	-3910		N OR LOCATION OF							
DIRECTOR	RESIDENCE OF DECEDENT		lyatt	sville			Prin	ice (Georges		
Ä	10e. STATE 10b. COUNTY	10c. CITY, 10	WN OR LO	CATION					10d. INSIDE CITY		
ā	Maryland Prince	Hyatt	tsvil	le					LIMITS?		
AL	10e. STREET AND NUMBER				101. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?		
FUNERAL	713 Sheridan Str				20783			Uni	ted	States	
Ž.	11. MARITAL STATUS 1 Never Married 2 Married	/ER IN U.S. ARM YES 2X NO		13. WAS I	ECENOENT OF HIS	PANIC ORIG	IN? (Specify Yes	or No-	14. RACE	- American Indian	
BY	3 Wildowed 4 Divorced	OR DATES		1 🗆 1		ecity:	Priceri, etc.)		Specif	ly:	
	15. DECEOENT'S EDUC	16a DEC	EDENT'S USU	AL OCCUP	TION				Blac	k	
ETE	(Specify only highest grade Elementary/Secondary (0-12)	(Give	e kind of work of Do NOT use reti	done during red.)	most of working	16	b. KINO OF BU	SINESS/IND	USTRY		
7	12		retary			F	ederal	Gove	rnme	ent	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S		Middle, Maiden			4	
w	Elijah Worthey					on-Ho			Dixon		
8	19e. INFORMANT'S NAME (Type/Print)	19b.	MAILING ADD	RESS (Stre					-		
10	M. Harriet Saylo	r	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City 5148 Settlers Park Drive, Vit								, VA 234
	20e METHOD OF DISPOSITION 1 D Burlet 2 Cremetion 3 Reme	numi from State	20b. PLACE AP	ND DATE OF DIS	SPOSITION	(Neme of	OA		CATION —		
	4 Donation 5 Donation Donation Donation Donation Donation		ony Mer	noria	1 Park	4/1	3 Lan	dover	, Ma	ryland	
	21. SIGNATURE OF JUNERAL SERVICE LIC	ENSEE		,	22. NAME AND ADDRESS OF FACILITY McGuire Funeral Service, Inc.						
	PicGuire Funeral Service, Inc. 7400 Georgia Ave. N.W., Wash. D.C. 20012 23 PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate										
CERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events b. OUE TO (OR AS A CONSEQUENCE OF):										
CERT	that initiated events reaulting in death) LAST d										
	PART II. Other algnificant condition	a contributing to dea	e underly	ing cause given	In Part I.	24s. WAS AN PERFOR		24b.	WERE AUTOPSY FINE		
AEDICAL				1					IMED?		AVAILABLE PRIOR TO COMPLETION OF CAU OF DEATH?
ME											1 YES 2 NO
	DID TOBACCO USE CONTE	RIBUTE TO CAUS	E OF DEAT	H YES [ON [UNCERTA	AIN 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINENT?	HOSPITAL:	26. PLACE	OF OEATH (C		10)					
ž	1 FYES 2 NO	1 Inpetient 2 ER/			HER: Nursing H	ome 5 Aeeldend	ce 6 🗆 Oth	er (Specify)			
ВУ РН	27. MANNER OF DEATH 1 Naturel 5 Pending 2 Accident Investigation	28e. OATE OF INJU (Month, Day, Ye	bar)	28b. TIME OF INJURY	M 1 [NJURY AT WORK? YES 2 NO	28d. DE	SCRIBE HOW II	NJURY OCC	URED	
E0	3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF IN. building, etc.	JURY — At hom (Specify)	e, farm, atreet	m, street, factory, office 28f. LOCATION (Street and Number or Rura City or Town, State)				or Rural R	outa Number,	
PLET	29e. CERTIFIER (Check only one)	CIAN: To the best of my I	knowledge, dast	h occurred at	the time, d	ate end place, end o	due to the co	ruse(e) end man	nner ee state	ıd.	
COMP	2 MEDICAL EXAMINE	R: On the basis of examin	nation and/or im	vestigation, in	my opinior	, death occured at I	the time, dat	e end place, en	d due to the	ceuse(s)	and manner se sta
BE (296. SIGNATURE AND TITLE OF CERTIFIES	Posta ita	-1111	_		29c. LICENSE N	NUMBER	1	29g DATE	SIGNED	(Month, Day, West)
2	30. NAME 1000 ADDRESS OF PERSON WHO	COMPLETED CAUSE OF	F DEATH STEM	27) (Type, Print		H2/2	-30	-	sque	19	1995
	AUGUSTO P. ROOM	wiguezo	1050 HIGHATURE	79.E	ay/	win Ct	Cp	Sm.	ms	20	748
	APR 14 1995	States Stainblen	12 Karlall		/		-	V			

DIVISION OF VITAL RECORDS, P.O. BOX 68760

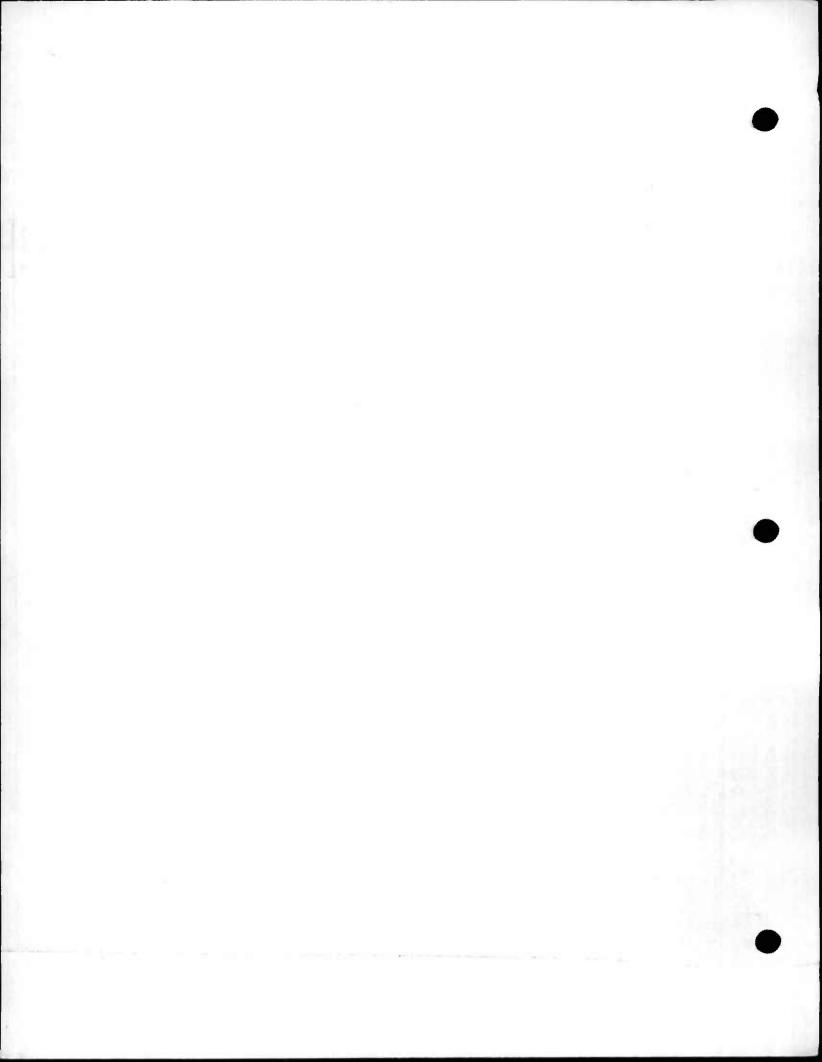
BALTIMORE, MARYLAND 21215-0020



Ar	nended #6	, 100	STATE OF I	13 9 MARYI AN	S, J	VV ,	M o	nt 5	ON	er g	C 9 5	0+4	3009
	1 - STATE REGISTRAR		OIAIL OI I	INITI LAN	CERTIF	ICAT	E OF	DEATI	H	REG. N	INE IO.		
	1. DECEDENT'S NAME (First, Mil									2. DATE OF DEATH			3. TIME OF DEATH
	Ernest W.	Tolso	on							April	8,	1995	03:10 a M
	4. SOCIAL SECURITY NUMBER		S. SEX	6. AGE (In yr	s. lest birthday)		R 1 YEAR	IF UNDER 24		7. DATE OF BIRTH		6. BIRTN	PLACE (State or Foreign
	578-54-9034	1	X M 2 □ F	959	4 YRS.	MONTHS	DAYS	HOURS	MIN.	Sep. 10,	1899	Countr	, irginia
	9e. FACILITY NAME (If not institu		et end number)			9b. CIT	Y, TOWN O	R LOCATION	OF DE			UNTY OF D	
E I	Regency Mur	eina =	and Poh	h C+	~		For	rrest			77		O
DIRECTOR	Regency Nur		and went	D. CC.			FUI	rest	<u> </u>	.e	PI	ince	George
뿐		b. COUNTY			10c. Cl	ry, town	OR LOCAT	ION					10d. INSIDE CITY LIMITS?
۵	Md.	Prince	e George	<u> </u>			M	-]	Fori	estville			1 X YES 2 NO
FUNERAL	10e. STREET AND NUMBER						101.	ZIP CODE			10g. Cl	TIZEN OF W	VHAT COUNTRY?
띮	7420 Marlbo	ro Pik	ce						207	747	Im	hati	States
5	11. MARITAL STATUS	1:	2. WAS DECEDEN	LEVER IN U.S	. ARMED	13.			NISPAN	C ORIGIN? (Specify			- American Indian,
ВУ Б	1 Never Merried 2 Mer 3 Wildowed 4 Divorced		FORCES? 1					city Cuben, 2X NO		, Puerto Ricen, etc.)		Specif	
	3 50 widowed 4 Divolced	'	unk		*								Black
COMPLETED	15. DECEDE (Specify only hig	NT'S EDUCAT	TION mpleted)	184	(Give kind of life. Do NOT u	Work done	OCCUPATIO	N t of working		16b, KIND OF E	BUSINESS/IN	IOUSTRY	
91	Elementary/Secondary (0-12)		College (1-4 or 5			1							
MP	llth				Specia	1 De	live	cy Cle	erk	U. S.	Post	Offi	ce
8	17. FATNER'S NAME (First, Middle							16. MOTHE	R'S NAM	NE (First, Middle, Maid	en Sumeme)		
品	Willis Wash	inngto	on Tolso	on				Luc	cy T	:ate			
2	19e. INFORMANT'S NAME (Type/				19b. MAILING	ADDRES	SS (Street er	nd Number of	Rural A	oute Number, City or 1	own, Stete, Z	ip Code)	
F	Fredric A.	Tolson	1		9107	Gre	enfie	eld La	ane,	Clinton	, Md.	2073	35
	20e. METNOD OF DISPOSITION 1 N Burlet 2 Cremetion	2 🗆 🗈	d door Care	20b. PL/	CE AND DATE	OFDISPO	SITION (Net	ne of		OAJE 20c.	LOCATION -	- City or To	wn, State
	4 Donation 5 Other (Spi		II from State		r, crematory or c			Comod	-ow	4/5k5	Suit1		Ma.
	21. SIGNATURE OF FUNERAL SI	ERVICE LICEN	SEE		11.1111	22.	NAME AN	O ADDRESS	OF FAC	ILITY		·	
	· R.n.	2/57								co. Morti			
							600 F	<i>kenned</i>	dy S	Street, N	. W.,	Wash	., DC
	23. PART I. Enter the disea ahock, or heart	isea, or con t fallure. Lis	nplicatione the	t ceused the	line.	not ente	r the mod	fe of dying	g, such	as cardiac or rec	plratory e	rrest,	Approximata Interval Between
	IMMEDIATE CAUSE (Final				2004111								Onset and Dasth
	disesse or condition resulting in death)		Fata	1 Arri	hythmi	a							5 months
					NSEQUENCE O								J months
z		b.	Card	liomyo	oathy	2° S	ma11	Vess	ם וב	isease			
음비	Sequentially flat conditions if any, leading to immediat		DUE TO	(OR AS A CO	SEQUENCE O	F):		1600	- d.	43case			
IFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury	c	C	ausin	chro	nic (conge	stive	e he	art fail	ure		10 yrs.
틸	that initiated events		DUE TO	(OR AS A CO	SEQUENCE O	F):					-		2200
CERT	resulting in death) LAST	d											
	PART II. Other algnificent of	conditions o	contribution to	death but -	et moultine	In Abo	i al calcal co	Legista de la composición dela composición de la composición de la composición dela composición dela composición dela composición de la composición de la composición de la composición de la composición dela composición d					
8						in the u	nderlying	ceuse giv	en in F		N AUTOPSY ORMED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă	Aortic an	id Mit	ral ins	uffic	lency					1 _ YES	25 NO		COMPLETION OF CAUSE OF DEATH?
MEDICAL	— Renal Ins	suffic	iency							_		i	1 YES 2 NO
ž	DID TOBACCO USE	CONTRIB	BUTE TO CA	USE OF D	EATH Y	ES 🔲	NO 🗆	UNCE	RTAIN				
5	25. WAS CASE REFERRED TO MI EXAMINER?		OCRITA	26. F	LACE OF DEA								
S I	1 TES 2X NO		OSPITAL:	ER/Outpatier	n 3 🗆 DOA	OTHE		5 🗆 Reelo	dence 6	Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATN	-	28e. DATE OF	INJURY	26b. Ttl	E OF	28c. INJU	RY AT		28d. DESCRIBE NOV	/ INJURY OC	CURED	
ВУР	1X Natural 5 Pen	ding atigation	(Month, D	ज्यु. रचवार)	IN.	JURY M	1 🔲 Y	ES 2 T	- 1				
- 1	2 Accident Inve. 3 Suicide 8 Cou		26e. PLACE O	F INJURY A	l home, ferm,	street, fac			-	281. LOCATION (Stree	t and Numbe	or Or Rumi A	oute Number
PLETED	_ 0 _ 000	rmined	building,	atc. (Specify)						City or Town, Ste	(e)	J	
ا ۳	29e. CERTIFIER 1 X CERTIFY	NG PHYSICIA	N: To the heat of	mu knowled	dian.		H. 150			o the ceusele) end m	y	= 1	-
u. II	(Check only '*Es) outility		··· to trie neet DI	···y KIIUWIEGGI	, awarn occurr	AG IN 1100 .	tirtte, date (ING DISCO. OI	nd dive t	o the ceuse(e) end m	sonner es ete	ded	

BE COM 29c. LICENSE NUMBER D02237 2 MD 12825 Old Fort Road, Ft. Washington, Md. 20744 Richard A. Farson, 31. DATE FILEO (Month, Day, Year)
APR 13 1995 JANUSAN PARALL

29d. DATE SIGNEO (Month, Day, Year) April 8, 1995



1. DECEDENT'S NAME (First, Middle, Last)

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HENE						

> Approximata intarvai Betwe Onset and Death

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

20912

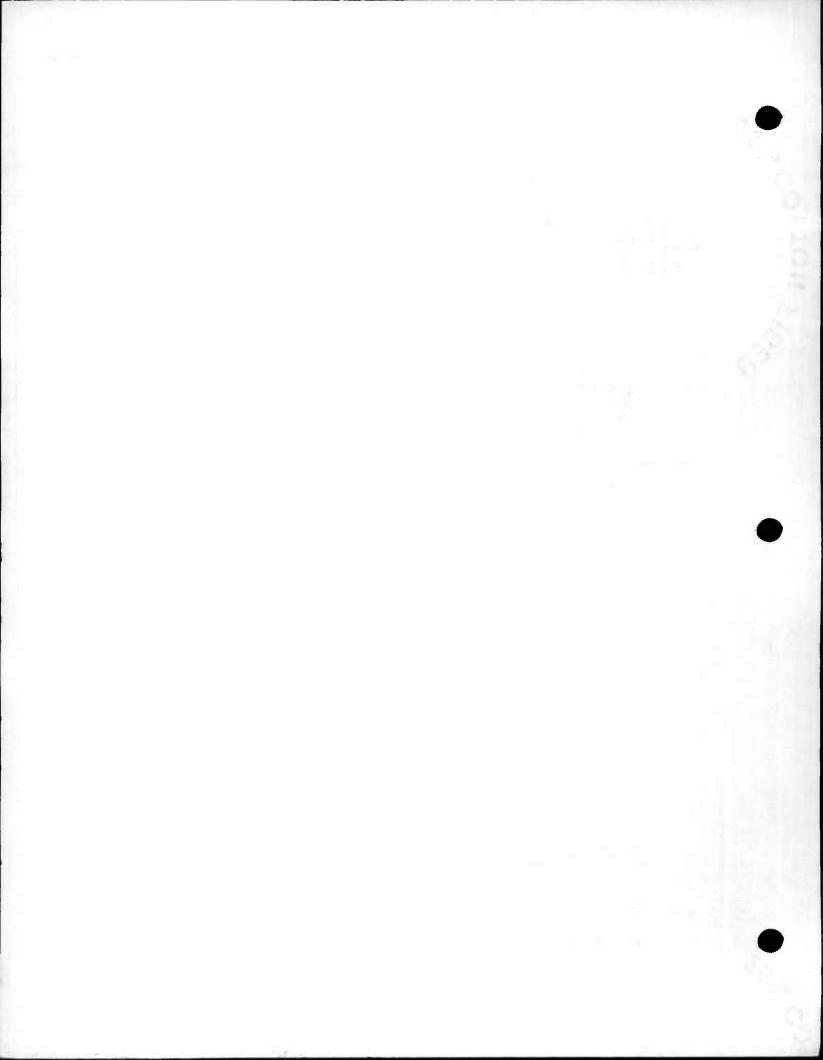
		1. DECEDENT'S NAME (First, Middle, Lest) STEPHEN LING	TSAO						DATE OF DEATH MONTH PRIL 12	,199	YEAR	TIME OF DEATH
_		4. SOCIAL SECURITY NUMBER 109 28 3857	5. SEX 6. AGE 1XDM 2 □ F 7.5	(In yrs. lest birthd	MONTH	DER 1 YEAR		HRS. 7.	DATE OF BIRTH (Month, Day, Year)			ACE (State or Foreign
2, 3 should	OR	9a. FACILITY NAME (If not institution, give st WASHINGTON ADV	reet and number) ENTIST HOS	SPITAL	96. С	A KO	N OR LOCATION MA PAP	OF DEATH	Harrier 10,	7	WTG6	MERY
020 physician. burial-transit permit. Pages 1, 2,	DIRECTOR	MD. PRINC	E GEORGES	10c.	CITY, TOW L'AKO	H OR LO	CATION PARK					Dd. INSIDE CITY LIMITS? X YES 2 \(\subseteq \) NO
nsit permi	FUNERAL	10e. STREET AND NUMBER 7000 ASPEN AVE					101. ZIP CODE 20912)				AT COUNTRY?
215-0020 attending physician. se as the burial-tran	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	2 XNO	1	If yes,	ECENDENT OF specify Cuban,	HISPANIC (ORIGIN? (Specify Ye uerto Rican, etc.)	_	14. RACE — Black, W Specify:	- American Indian, White, etc.
21 al or for u	COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)		18a. DECEDEN (Give kind life. Do NO	T'S USUAL of work don T use retired	ne durina	TION most of working		16b. KIND OF BU	SINESS/INDU		RIENTAL
MARYLAND 21 retained by the hospital or 5 should be detached for unotified at once.	COMP	17. FATHER'S NAME (First, Middle, Lest)	5+	LAB TI	ECHN	ICI	ts. MOTHE		(First, Middle, Maiden	Surname)		
MARYL retained by 5 should be notified at	TO BE	WING TS 19e. INFORMANT'S NAME (Type/Print)	AO	19b. MAIL			et and Number or	A I Rurel Rout	LAN Number, City or Tow	vn, State, Zip	Code)	
		NANCY TSAO 20a. METHOD OF DISPOSITION 1 1 Burlel 2 Cremation 3 Remo	ovel from State	Db. PLACE AND DA	TEOFDISP	OSITION	S 10e	I		CATION — C		
Pag Pag		41 Donation 5 Other (Specify)	1	FORGE WAS					IL 45 1995 HOME INC		<u> </u>	
BALT lifter death. by the funers	-	23. PART I. Enter the diseases, or c	Melea	el distribution of	I.	ı.W.	WASHIN	IGION	, D.C. 2	0012		
24 hours 7 filled in tion, or n		shock, or seart feliure. I iMMEDIATE CAUSE (Final disease or condition resulting in death)	iat only one cause on	aach lina.		ar tha r	noda or dying	g, auch a	n cardiac or reap	iratory arre	rat,	Approximata interval Betwee Onset and Dec
P 2 2 2	z			A CONSEQUENCE	E OF):	3						
Se de la cian	CERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury		A CONSEQUENCE								
G # P	CERTI	that initiated events resulting in death) LAST		A CONSCIOUENCE	- OF).							
ORDS that the ed by the th and Many Inju	MEDICAL	PART II. Other aignificant conditions	contributing to death	but not reaultin	ng In the	undarly	ing cause giv	en in Par	1 . 24a. WAS AN PERFOR	RMED?	AW	PRE AUTOPSY FINDING AILABLE PRIOR TO EMPLETION OF CAUSE DEATH?
に 5 0 2 2	1	DID TOBACCO USE CONTR	RIBUTE TO CAUSE (OF DEATH	YES 🗆	NO	☐ UNCE	RTAIN [-		1[YES 2 NO
JE VITAL F SiCIAN: The law r certificate has be the State Dept.	PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 XInpetient 2 ER/Out	26. PLACE OF D	ОТН	ER:	ome 5 - Resid	ienca 6 🗆	Other (Specify)			
	BY PHY	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)		TIME OF INJURY M	28c. I	NJURY AT WORK? YES 2 N	284	d. DESCRIBE HOW I	NJURY OCC	URED	
DIVISION L OR ATTENDING F DIRECTOR: After t hours after death item 28 is mar		3 Suicide 8 Could not be detarmined	28e. PLACE OF INJUR building, atc. (Spi	Y — At home, ferr	m, atreet, fe	ctory, of	fica	261	LOCATION (Street a City or Town, State)	and Number o	x Rural Route	Number,
DIV PITAL OR A FRAL DIREC In 72 hours	COMPLET		EIAN: To the best of my known: I: On the bests of examination									
TO THE HOSPITAL (TO THE FUNERAL C be filed within 72 h IMPORTANT: If it	BE CC	296. SIGNATULE AND THE OF CERTIFIER	I m				29c. LICENS	SE NUMBER		29d. DATE	SIGNED (Mo	onth, Day, Year)
263	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF D	EATH (ITEM 27) (7)	ype, Print)	_	D219	900		► AP	RII 1	2, 1995

7610 CARROLL AVE #280 TAKOMA APRK, MD.

32. REGISTRAN'S SIGNOURS

SMITH HO

31. DATE FILED (Month, Day, Year) APR 13 1995



requires that the

OR ATTENDING PHYSICIAN: The law

been at, of

the State Dept.

this c

After

DIRECTOR: hours after

핆

Pages 1, 2, 3 should

permit.

cremation, 9 prior signed by the attending phy Health and Mental Hygiene

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Alliene Kimball Tilley 1995 April I6 1:40a w 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 578-58-0910 1 - M 2XX 83 Dec 20,1911 Virginia 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Clinton Southern Maryland Hospital Center DIRECTOR Prince Georges RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Maryland Prince George's Clinton 1 TES 2XXNO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 7309 Vista Lane 20735 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) RN Nursing Administrator Health Care 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) at Oscar Allison Nicholson BE Katherine Roberson notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Raymond A. Lewis 311 Bent Creek Drive, Greer South Carolina 29651 9 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must Fort Lincoln Cem April 19,1995 Brentwood, Maryland 4 Donation 5 Other (Specify) examiner 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 6633 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Old Alexander Ferry Road, Clinton,Md 20735 medicai 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heart fallure. List only one cause on each line. Interval Between **IMMEDIATE CAUSE (Final** Onset and Death other traumatic event, the disease or condition 21/2/10 reaulting in death) OUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 inlury. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a, WAS AN AUTOPSY any 10 1 | YES 2 | 10 Shows OF DEATH? 01 LO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES □ NO □ UNCERTAIN □ 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) Hem HOSPITAL: OTHER: 1 YES 2 N atient 2 ER/Outpatient 3 DOA 4 - Nursing Nome 5 - Rasidenca 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED marked. 1 Matural 5 Pending BY 1 YES 2 ND 2 Accident 3 Sulcide 28s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28 is 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 4 Nomicide TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If Item 2 29a, CERTIFIER ING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and manner as stated. MEDICAL EXAMINER: On the besis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

29c. LICENSE NUMBER 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ADEL LEVINE 18010 LD Brancis

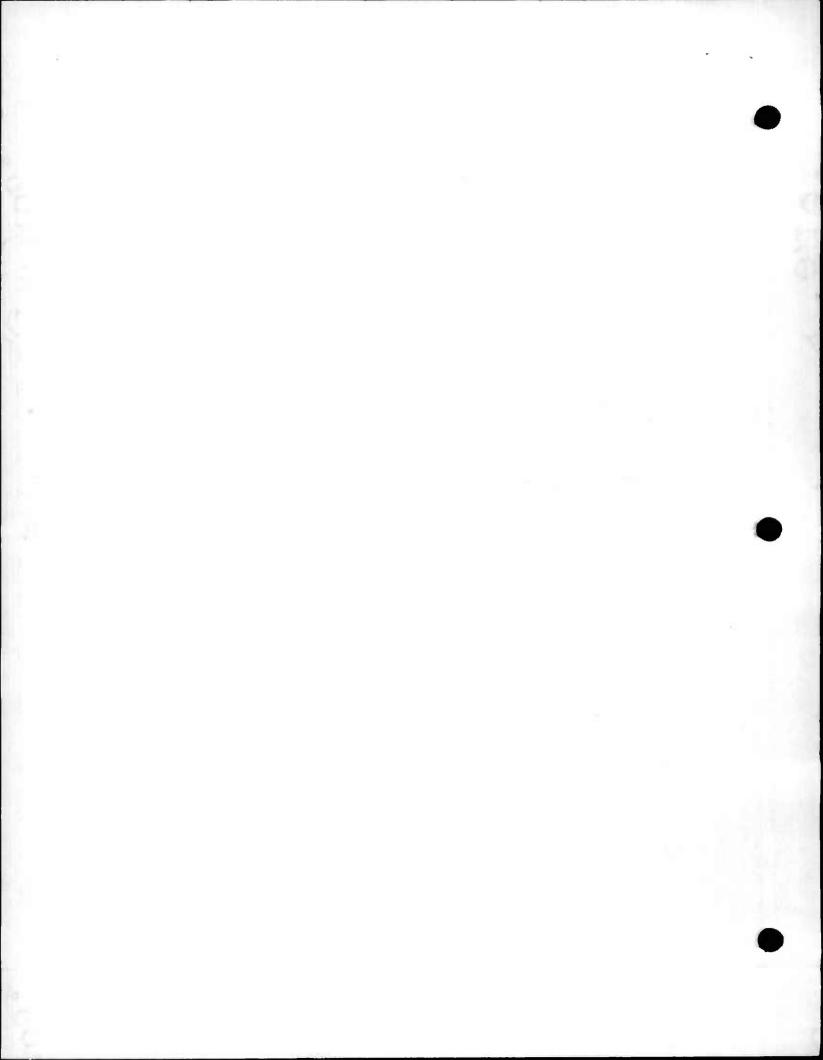
31. DATE FILED (Month, Day, APR 1 8 1995

MATURE AND TITLE OF CERTIFIER

32. RIGISTRAD'S SIGNATURE

ONMH-16 Rev 1/89

29d. DATE SIGNED (Month, Day, Year)



Louis V. K

Kauffan I *8 1995

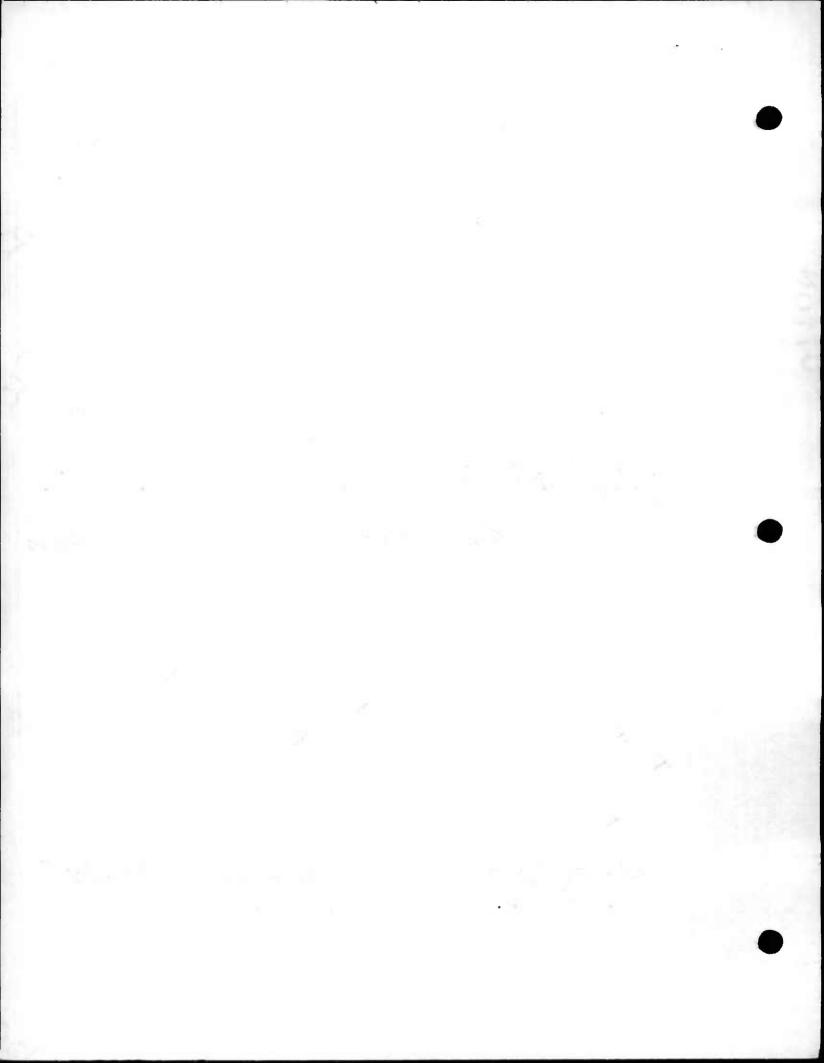
1995

	•										Q	1	3012
	1 - FOR STATE REGISTRAR	STATE OF	MARYLAND) / DEPAR						HYGIEN REG. NO	-	J	0012
	1. DECEDENT'S NAME (First, Middle,	*							2. DATE OF		W 0.0 F	YEAR	3. TIME OF DEATH
	Franci	11.			Tho	mpso	n		APPI1	15,	1995	TEAN	3:30 P M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.		IF UNDER	DAYS	IF UNDER	24 HRS.	7. DATE OF (Month, E	BIRTH (av. Year)		8. BIRTH	PLACE (State or Foreign
	579-01-4049	1 🔀 M 2 🗌 F	,	78 _{YRS.}	WONTHS	UAYS	HOURS	MIN.	Oct]	1, 1	916	Vir	ginia
	9a. FACILITY NAME (If not institution,						OR LOCATIO					NTY OF DE	
Ö	2600 Brinkley H		ent 204	4	Fo	rt W	ashi	ngto:	n		Pri	nce (George's
[E	RESIDENCE OF DECEDEN 10a, STATE 10b, C	OUNTY		10c CIT	Y, TOWN (OB LOCAT	ION						10d. INSIDE CITY
DIRECTOR	Maryland Pri	ince George	1 _S			-23	gton						LIMITS?
-	10e. STREET AND NUMBER						. ZIP CODE				100 CIT	IZEN OF W	1 YES 2 NO
FUNERAL	2600 Brinkley F	Road Apartm	ent 204	1				0744			•		
=	11. MARITAL STATUS	12. WAS DECEDE			13.	WAS DEC			IC ORIGIN? (Specify Ver			States
됴	1 Never Married 2 Married		YES 2	□NO		If yes, sp	ecity Cuba	n, Mexicar	n, Puerto Rici	in, etc.)	01110-		- American Indian, White, etc.
BY	3 Widowed 4 Divorced					1 1 163	26 140	Specify				Whit	
COMPLETED	15. DECEDENT*! (Specify only highest	S EDUCATION grade completed)	16a.	DECEDENT'S	USUAL O	CCUPATIO	ON et of workin		16b. KI	ND OF BUS	SINESS/INC	DUSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5	+)	(Give kind of a life. Do NOT us			or or working	v	7.7-	1. 2 U.		O	
M M	12		14.	ieter I	reaue	šT.			was	urnd	con (as C	ompany
	17. FATHER'S NAME (First, Middle, La: Frank Arthur								WE (First, Mide		Sumame)		
BE	19a. INFORMANT'S NAME (Type/Print)	-							Plaug				
၉	Dorothy A. Tho		1	196. MAILING									gton, MD
		-	700000					10, 1	_				
	20a. METNOD OF DISPOSITION 1 Burlat 2 Department 3 4 Donation 5 Other (Specify)	Removal from State	cemetery,	crematory or of Cremat	ther place)	Na T	me of	7 10	OATE			City or Tov	yland
	21. SIGNATURE OF FUNERAL SERVI		TLEE	Cremar	OLY,	NAME AN	D ADDRES	L / , L	כעי		ши	1, Plat	yrana
- 1	·(//	151	1						Lee				, Inc.
	103401	100	100		60	633 (Old A	Alexa	ander	Ferr	y Rd.	.,Cli	nton, Md.
	23. PART I. Enter the diseases shock, or heart fall	i, or complications the	it caused the use on each i	death. Do r line.	not antar	the mo	da of dyl	ng, auch	aa cardiad	or reapi	ratory an	rest,	Approximate interval Between
	IMMEDIATE CAUSE (Final	G											Onset and Death
	disease or condition resulting in death)	a. OUE TO	MPHY	SEA	117								Yours
- 4		OUE TO	OR AS A COR	SEQUENCE O	F):								1
CERTIFICATION	Sequentially list conditions,	b. DUE TO	(OR AS A CON	SECREMOE OF	E).								
TA:	if any, laading to immediata cause, Entar UNDERLYING		TOTT HS A COIL	SECOENCE O	г).								
윤	CAUSE (Disease or injury that initiated events	C. DUE TO	OR AS A CON	SEQUENCE OF	F):								
F	reaulting in death) LAST												
· .	DART II Oshoo double a												1
MEDICAL	PART II. Other algnificant cond	ditiona contributing to	daath but no	ot reaulting	in tha un	derlying	g cauaa g	iven in i	Part I. 24	a. WAS AN PERFOR			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă									1	YES 2	NO		COMPLETION OF CAUSE OF DEATH?
×										•		1	1 _ YES 2 _ NO
Ž	DID TOBACCO USE CO				$\overline{}$	NO [UNC	ERTAIN					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDIC EXAMINER?	HOSPITAL:		LACE OF DEAT	OTHER				-				
IYS	1 YES 2 NO	1 Inpatient 2		-	4 🗆 Nun	sing Home	5 Re	sidence	6 Other (S	-			
	1 Netural 5 Pending	28a. OATE Of (Month, i	Pay, Year)	28b. TIM INJ	E OF URY	28c. INJI	RK?		28d. DESCR	IBE NOW II	NJURY OC	CURED	
B	2 Accident Investiga		OF INJURY AL	home form			ES 2	NO					
8	3 Suicide 8 Could not determine	or building	atc. (Specify)	ome, terri, l	erwet, ISCT	ory, orner			City or 7	ON (Street a own, State)	nd Number	or Rural Ro	oute Number,
COMPLET	29a. CERTIFIER 1 CERTIFYING	DAVOICIAN, To Market	0		9.00		CONT.						
M M	CONSCRIPTION .	PNYSICIAN: To the best of AMINER: On the basis of a											
- 11	296, SIGNATURE AND TITLE OF CER				.,, 0					- praca, an			
H	2112	111					ZVC. LICE	NSE NUM	3 / /		29d. DAT	SIGNED (Month, Day, Year)

who completed cause of Death (ITEM 27) (Type, Print) #602

M.D., 8926 Woodyard Road, Clinton, Maryland
32. RESISTRARY SIGNATURE
July Division Reviel

20735



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the thospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

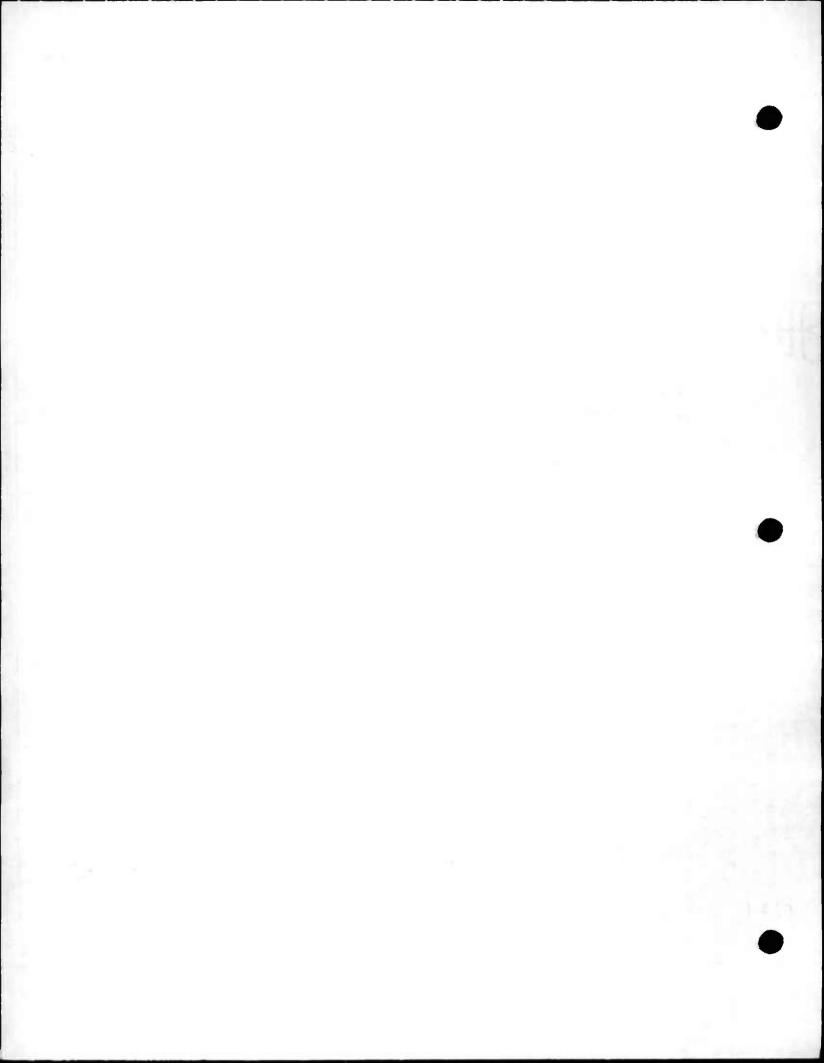
									95)	3013
	1 - STATE REGISTRAR	STATE OF I				OF DEATH	MENTA	L HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)				TORTE	O. DERIII	2. DATE	OF DEATH		1	. TIME OF DEATH
1	Garland Patrick Va	aughn					MONT	H D	1005	YEAR	78
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. let	A fileh de l				il 11,			5:30 A. M
	226-48-6403	1 ☑ M 2 ☐ F			IF UNDER 1 Y	EAR IF UNDER 24 HRS. AYS HOURS MIN.	(Mont	OF BIRTH h, Day, Year)		Country)	ACE (State or Foreign
		41	54	YRS.		11/42		14,	1 040	/irgi	nia
-	9e. FACILITY NAME (If not institution, give str				9b. CITY, Τ	OWN OR LOCATION OF	DEATH		9c. COUN	TY OF DEA	ТН
DIRECTOR	789 Quince Orchard	Blvd.	#13		Gaith	ersburg			Mont	gomer	-v
5	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY			T							
<u>E</u>					Y, TOWN OR I					1	Od. INSIDE CITY LIMITS?
	Maryland Montgo	mery		Gai	thersb					1	YES 2 NO
FUNERAL	10e. STREET AND NUMBER					101. ZIP CODE			10g. CITIZ	EN OF WH	AT COUNTRY?
買	789 Quince Orchard	Blvd. 🕯	13			20878			Unit	ed St	ates
5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AF		13. WA	DECENDENT OF HISPA	ANIC ORIGI	N? (Specify Yes	or No-	14. RACE -	American Indian
ВУ	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE Y	WAR OR DATES	NO	1 [FE, specify Cuben, Mexic YES 2 X NO Spec	en, Puerto	Rican, etc.)		Specify:	White, etc.
											White
	15. DECEDENT'S EDUC (Specify only highest grade of	CATION completed)	16a. DE	CEDENT'S	USUAL OCCL	IPATION ng most of working	166	. KIND OF BU	SINESS/INDU	JSTRY	
Ш	Elementary/Secondary (0-12)	College (1-4 or 5	H4a	Do NOT us	se retired.)	ng most of working					
₩ A	8		Bui	lding	g Serv	ice Worker	· Mo	ontgom	erv C	ounty	Schools
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S N				0.110	DUNOVID
BE	Earl Vaughn					Annie M	finto	n			
	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (S	treet and Number or Rural			n. State Zin (Codel	
임	Edna Charleen Vaug	hn									1000000
1	20e, METHOD OF DISPOSITION 1 N Burlel 2 Cremetion 3 Remo				OF DISPOSITION		VU . 1/ .	13, Ga	CATION - C	sburg	MD 20878
	1 N Buriel 2 Cremetion 3 Remo	rval from State	cemetery cre	matory or o	ther place)	al Park	1				
	21. SIGNATURE OF FUNERAL SERVICE INC.	ENSEK)	raiki	awii r		AL PARK	4/	13 Roc	kville	e, Ma	ryland
	- 7 1	00			DeVo	l Funeral	Home				
	XC (J							there	hura	MD 20877
	23. PART I. Enter the diseases, or co	omplicatione tha	t caused the de	ath. Do r	not anter the	a moda of dying, au-	ch aa care	diac or respi	ratory arre	at.	Approximata
	shock, or heart fellure. L IMMEDIATE CAUSE (Faris)	lat only one cau	ise on each line								Intarval Between
1 1	dienage or condition	D1 0	11 0								Onset and Death
1	resulting in death) e	Renal C	(OR AS A CONSE								2 years
		502 10	(ON AS A CONSE	DOENCE O	r):						
CERTIFICATION	Sequentially list conditions, b.	DUE TO	(OR AS A CONSE	NIENOE O							-
F	if any, leeding to immediate cause. Enter UNDERLYING	DOE 10	(OR AS A CONSE	JUENCE O	-):						
일	CAUSE (Disease or Injury C	OUE TO	(OB 40 4 00W05								-
Ē	that initiated events resulting in death) LAST	DOE 10	(OR AS A CONSE	JUENCE OF	F):						
#	d	•									
1 . 1	PART II. Other significent conditions	contributing to	death but not r	esultino	n the under	rivino cause given ir	Pert I	24a. WAS AN	ALITOBEV	245 W	EBE ALITOROV FINIDINGO
MEDICAL	100/10					Tyring dudoo giraii ii		PERFOR		A	ERE AUTOPSY FINDINGS MILABLE PRIOR TO
ā							—	1 TYES 2	NO X		OMPLETION OF CAUSE F GEATH?
										1	YES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTR	IBUTE TO CA	USE OF DEA	TH YE	S NC	UNCERTAI	N 🗆				
8	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSBITAL	28. PLAC	E OF DEAT	TH (Check only	one)					
S	37	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER:	Home 5 X Residence	8 🗆 Othe	r (Specify)			
된	27. MANNER OF DEATH	28e. DATE OF (Month, D		28b. TIM	E OF 284 URY	c. INJURY AT WORK?	26d. DES	CRIBE HOW I	NJURY OCCL	JRED	
ВУ	1 X Natural 5 Pending 2 Accident Investigation	(monn), or	ay, romy	1145	M 1	YES 2 NO					
	3 Suicide 6 Could not be	28e. PLACE O	F INJURY — At ho	me, ferm, r	treet, factory,	office	28f. LOC	ATION (Street a	and Number o	r Rural Rout	te Number.
Ē	4 Homicide determined	bullding,	etc. (Specify)				City	or Town, State)			
9	29e. CERTIFIER		- Annual Control of								
COMPLETED	(Check only one) 1 X CERTIFYING PHYSIC PHYSIC (Check only one)										
8	2 MEDICAL EXAMINER	. Un the beels of ex	umination end/or i	rrvestigatio	n, in my opini	on, death occured at the	e time, date	end plece, en	d due to the	Couse(S) e	nd menner es stated.
ш	29b. SIGNATURE AND TITLE OF CENTIFIED	0.500	na.			29c. LICENSE NU	MBER		29d. DATE	SIGNED (onth, Day, Year)
0 0	1 taxal	un		,		D35635			> '	1/11	195
유	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CALE	E OF DEATH WEEK	4 27 /Keni	- Michael						

, 18111 Prince Phillip Drive #327, Olney, Maryland 20832

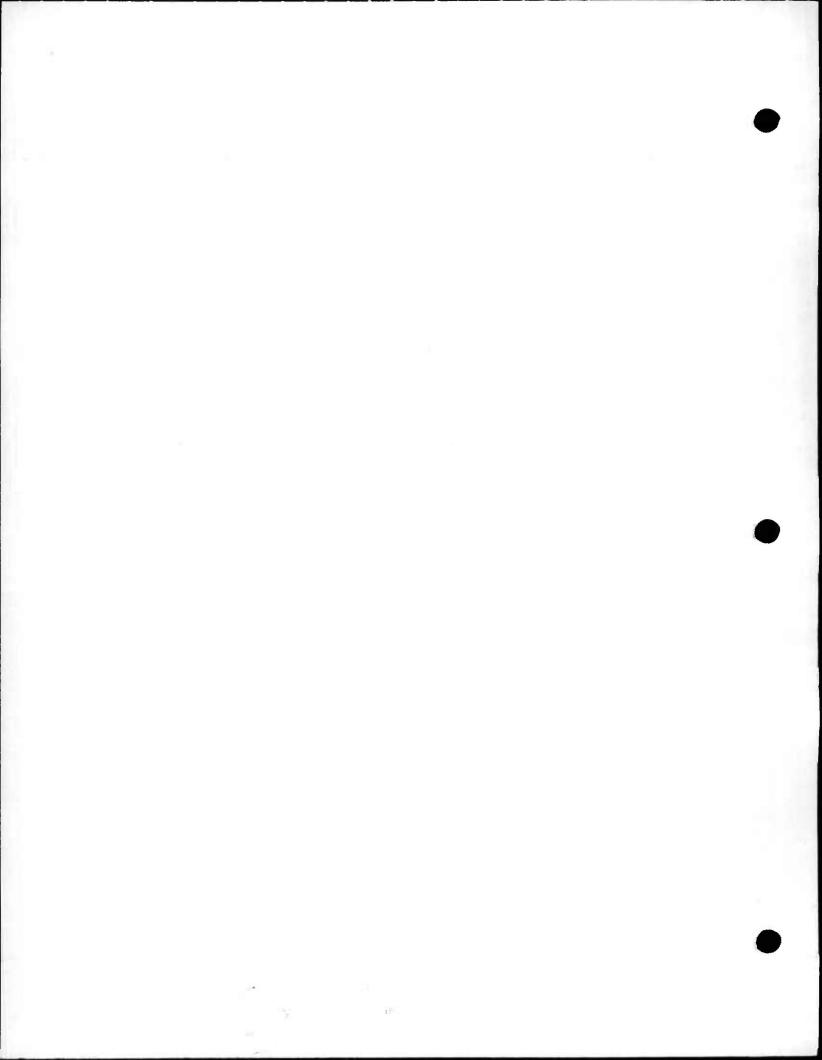
7+1

Joseph Kaplan,
31. DATE FILED (Month, Day, Vaer)
APR 12 1995

M.D.,



		FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF H	IEALTH AND M	ENTAL HYGIEN	Ε	
		1. DECEDENT'S NAME (First, Middle, Last) Francis R.	Vroom			1	2. DATE OF DEATH	ľ995 ľ	EAR 6 PM M
29		4. SOCIAL SECURITY NUMBER 578.03.9041	1 XM 2 🗆 F 8	(In yrs. last birthday) O YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTNPLACE (State or Foreign Country) shington D.C.
2, 3 should	TOR	Anne Arundel Medi	II CO MANAGEMENT		Annapo	or location of deal	TN	9c. COUNTY	OF DEATH Arundel
permit. Pages 1,	DIRECTOR	10a. STATE 10b. COUNTY	gomery		y, town on Locat	TION			10d. INSIDE CITY LIMITS? 1X YES 2 NO
120	ERAL	10m. STREET AND NUMBER 9303 Adelaide Di				20817		U.S.	OF WHAT COUNTRY?
15-0020 ending physician. as the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Divorced	12. WAS DECEDENT EVER IN FORCES? YES IF YES, GIVE WAR OR DA	U.S. ARMED 2 NO ATES	tt yes, sp	CENOENT OF NISPANIC hecity Cuban, Maxican, is 2 NO Specify:	C ORIGIN? (Specify Year Puarto Ricen, etc.)	or No — 14.	Black, White, etc. Specify: White
or att	LETED	15. DECEDENT'S EOUC. (Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	16s. DECEOENT'S (Give kind of w life. Do NOT us	USUAL OCCUPATION work done during more retired.)	ON ast of working	16b. KIND OF BUS	SINESS/INDUS	TRY
AND 2 the hospital detached to	once.	12		Linesmar	1		Pepco		
Y L	W	George William	m Vroom				A. Butler	,	
MAR retained to 5 should	TO BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILINO	ADDRESS (Street a	and Number or Rural Roo			de)
E, R	9	Mary Miller Vroom 20a. METHOD OF DISPOSITION				Dr. Beth			
BALTIMORE, er death. Page 6 may be the funeral director, page val.	must	1 X Burial 2 Cremation 3 Ramov	vat from Stata	PLACEAND DATE OF PROPERTY OF OF THE	her place) aven Cei	meterv	4/10 Silve		or Town, Stata
ALTIM death. Page funeral direc	examiner	21. SIGNATURE OF FUNERAL SERVICE LICE	INSEE		22. NAME AN	NO ADDRESS OF FACIL	Joseph	Gawler	's Sons
BAL after deat by the fun moval.		KULLYM	y eles			WI AVE NW			
urs af in by	medical	23. PART I. Enter the disesses, or co shock, or heart failure. Li	omplications that caused ist only one ceuse on e	the death. Do n sch line.	ot entar the mo-	de of dying, such	as cerdiac or reepi	ratory arrest	, Approximate interval Between
orithing ho sletely filled remation, o	event, the n	IMMEDIATE CAUSE (Final disease or condition resulting in death)	DUE TO (OR AS A Udity allum DUE TO (OR AS A	yniatry	y fewle	سلله			Onset and Death
6876 secuted v nd comp burial, c			deinalin	Linku	aus to	monis			en
OX 68 be exect iclan and for to bu	r other traumatic	Sequentially list conditions, if any, isading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF	7:				
certificate ding physical chygiene pri	other tr	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	·):			-	
D 6 5 -	9 1 111	resulting in death) LAST							2.5
0 E E	y injury.	PART II. Other significant conditions	contributing to deeth be	ut not resulting i	n the underlying	g ceuse given in Pr			24b. WERE AUTOPSY FINDINGS
D the start	S ()						PERFOR 1 TYES 2	Α .	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?
9 9 9	shows an	DID TODACCO LICE CONTRI	Inlite to chaire o	C DEATH VE			_		1 TES 2 NO
TAL The law ate has b ate Dept.	A 13	DID TOBACCO USE CONTRI		PLACE OF DEAT		UNCERTAIN			
_ = = =	Item ICL				OTHER:				
VIIAN:	2 8		HOSPITAL: 1 ☐ tripatient 2 ☐ ER/Outp	atlent 3 DOA	4 Nursing Nome	e 5 Residence 6	Other (Specify)		
OF VI. HYSICIAN: his certifical with the Sta	ं। ≥ ।	1 ☐ YES 2 ☑ NO 27. MANNER OF OEATN		26b. TIME	4 Nursing Nome E OF 26c, INJUNY	URY AT 2	Other (Specify)	JURY OCCUR	ED
N OF VI IG PHYSICIAN: er this certification with the St	marked, or BY PHY	1 VES 2 NO 27. MANNER OF OEATN 1 Netural 5 Pending 2 Accident Investigation	1 Department 2 ER/Outp 28a. DATE OF INJURY (Month, Dey, Year) 28a. PLACE OF INJURY	26b. TIME INJU	E OF 26c, INJI WOI M 1 Y	URY AT 2 PRK? YES 2 NO	ed. OESCRIBE NOW IN		
TENDING PHYSICIAN: TOR: After this certifical after death with the St	28 is marked, or TED BY PHY	1 ☐ YES 2 ☑ NO 27. MANNER OF OEATN 1 ☑ Netural 5 ☐ Pending	1 □ Inpatient 2 □ ER/Outp	26b. TIME INJU	E OF 26c, INJI WOI M 1 Y	URY AT 2 PRK? YES 2 NO			
DIVISION OF VI AL OR ATTENDING PHYSICIAN: AL DIRECTOR: After this certific; 2 hours after death with the Si	it item 28 is marked, or IPLETED BY PHY	1 YES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only)	1 theatlent 2 ER/Outp 28s. DATE OF INJURY (Month, Dey. Year) 26s. PLACE OF INJURY building, stc. (Speci	26b. TIME INJU	4 Nursing Nome E OF 26c, INJI WO 1 Yestreet, factory, office	URY AT RK? YES 2 NO 2 end place, and dua to	ted. OESCRIBE NOW IN tel. LOCATION (Street a City or Town, State)	nd Number or F	
DIVISION OF VI AL OR ATTENDING PHYSICIAN: AL DIRECTOR: After this certific; 2 hours after death with the Si	it item 28 is marked, or IPLETED BY PHY	1 YES 2 NO 27. MANNER OF DEATN 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only)	1 theatlent 2 ER/Outp 28s. DATE OF INJURY (Month, Dey. Year) 26s. PLACE OF INJURY building, stc. (Speci	26b. TIME INJU	4 Nursing Nome E OF 26c, INJI WO 1 Yestreet, factory, office	URY AT RK? YES 2 NO end place, and due to eath occured at the tim 29c. LICENSE NUMBE	ted. OESCRIBE NOW IN ted. LOCATION (Street a City or Town, State) the cause(a) and man me, date and place, end	nd Number or F	Rural Poule Number, suse(a) and manner as stated. GNED (Month, Day, Year)
OR ATTENDING PHYSICIAN: ORECTOR: After this certifical ours after death with the St	it item 28 is marked, or IPLETED BY PHY	1 YES 2 NO 27. MANNER OF OEATN 1 Netural 5 Pending Investigation 2 Accident Could not be detarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER	28a. DATE OF INJURY (Month, Dey, Year) 28a. PLACE OF INJURY building, stc. (Speci	29b. TIME INJU	4 Nursing Nome E OF 26c, INJ WO 1 Y WO 1 Y Y street, factory, office od at the time, data n, in my opinion, de	URY AT RK? YES 2 NO 2 end place, and due to eath occured at the time	ted. OESCRIBE NOW IN ted. LOCATION (Street a City or Town, State) the cause(a) and man me, date and place, end	nd Number or F	Rural Poule Number, suse(a) and manner as stated. GNED (Month, Day, Year)
DIVISION OF VI AL OR ATTENDING PHYSICIAN: AL DIRECTOR: After this certific; 2 hours after death with the Si	PORTANT: If Item 28 is marked, or BE COMPLETED BY PHY	1 YES 2 NO 27. MANNER OF CEATN 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29a. CERTIFIER (Check only orne) 2 MEDICAL EXAMINER:	28a. DATE OF INJURY (Month, Dey, Year) 28a. PLACE OF INJURY building, stc. (SpecialAn: To the best of my knowle: On the basis of axamination COMPLETED CAUSE OF DEA	29b. TIME INJU	4 Nursing Nom E OF 26c. INJ URY M 1 Y WO 1 Y Y In Y Nor In The Action, office od at the time, data n, in my opinion, de	URY AT RK? YES 2 NO end place, and due to eath occured at the tim 29c. LICENSE NUMBE	ted. OESCRIBE NOW IN ted. LOCATION (Street a City or Town, State) the cause(a) and man me, date and place, end ER	nd Number or F	Rural Poule Number, suse(a) and manner as stated. GNED (Month, Day, Year)



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Durs after death. Page 6 may be retained by the hospital or attending physician.

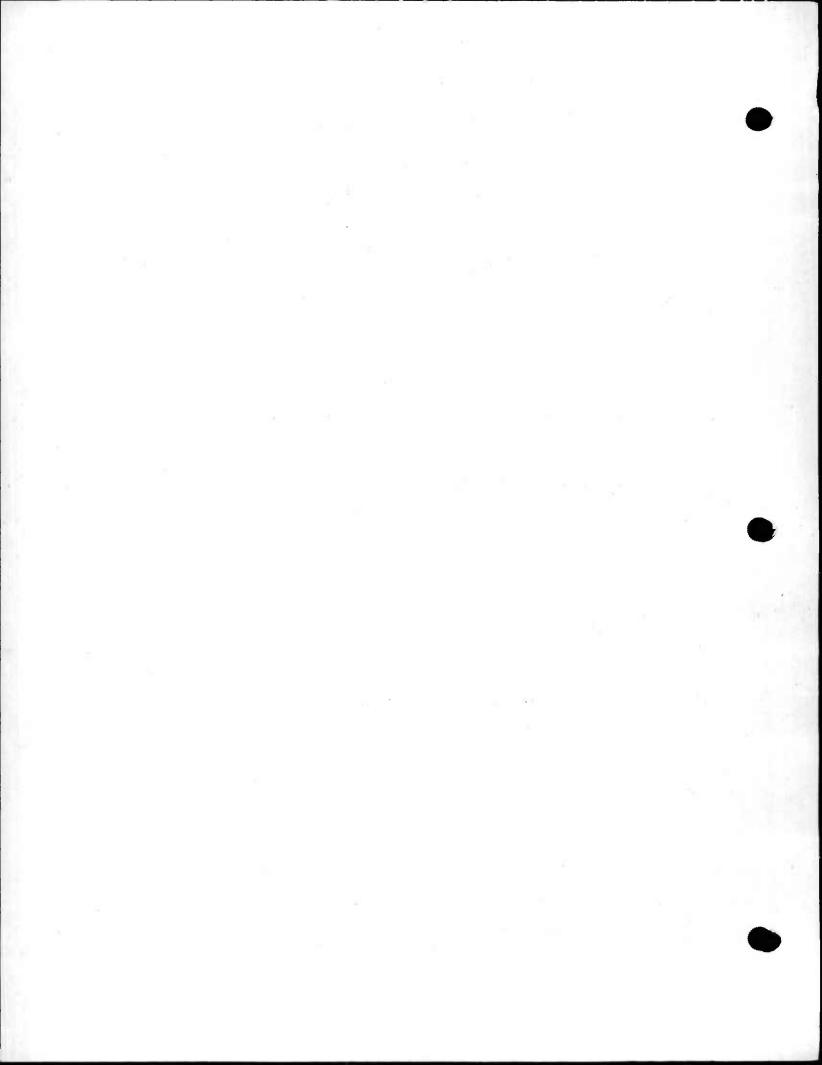
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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

\neg					OLITTI	IOAI	_ 01	DEA			REG. NO.			
	1. DECEDENT'S NAME (First,	Middle, Last)								2. DAT MON	E OF DEATH	Y	YEAR	3. TIME OF DEATH
			Clara	Virg	inia	V	ansa	nt		AT	ril 11	199		7:35 a M
	4. SOCIAL SECURITY NUMB	ER	5. SEX	8. AGE (In y	rs. last birthday)	-	R 1 YEAR	IF UNDER			E OF BIRTH oth, Day, Year)		8. BIRTH Countr	IPLACE (State or Foreign
	214-22-1617	7	1 🗆 M 2 💢 F	89	YAS.	MONTHS	DAYS	HOURS	MIN.	Fel	b. 26,1	906		vland
	90. FACILITY NAME (If not in:	stitution, give s	treet and number)			9b. CIT	Y, TOWN	OR LOCATI	ON OF DI				NTY OF D	M
DIRECTOR	Frederic	c Memo	rial Hos	nital			Fred	leric	k			Fr	eder	ick
5	RESIDENCE OF DEC	EDENT					1100					11	cuci	ICK
뿐	10a. STATE	10b. COUNTY			10c. CI1	Y, TOWN	OR LOCAT	TION						10d. INSIDE CITY LIMITS?
	Maryland		Frederi	ck		Fre	deri	ck						1 X YES 2 NO
₹ I	10e. STREET AND NUMBER						10	ZIP COD	E			10g. CIT	IZEN OF V	WHAT COUNTRY?
FUNERAL	8000	Sunny	brook Ct	•				2170	2			Uni	ted	States
5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.	S. ARMED	13.	WAS DEC	ENDENT (OF HISPAI	NIC ORIG	IN? (Specify Yee	or No-	14. RACE	E — Americen Indien,
	1 Never Merried 2		FORCES? 1	MAR OR DATE	SNO			2 NO			Ricen, etc.)		Speci	k, White, etc.
BÁ	3 Widowed 4 Divo	rced						/					-	White
	15. DECI (Specify only	EDENT'S EDU	CATION completed)	110	Se. DECEDENT'S (Give kind of	USUAL C	OCCUPATION PRO	ON and weekly		16	ib. KIND OF BUS	INESS/IN	DUSTRY	
4	Elementary/Secondary (0		College (1-4 or 5	F)	life. Do NOT u	se retired.)	ourng me	at or worki	''V					
Ē	7		_		Home	make	r				Own Ho	me		
COMPL	17. FATHER'S NAME (First, MI	iddle, Last)						18. MOT	HER'S NA	ME (First	Middle, Malden	Surname)		
BE		Har	ry Augu	stus	Brashe	ars			Επ	ma			Lind	sav
- 1	19e. INFORMANT'S NAME (7)	/pe/Print)			19b. MAILING	ADDRES	S (Street a	nd Numbe	_		mber, City or Town			July
임	AnnaBelle H	Biding	er		1						ederick			702
	20a, METHOD OF DISPOSITI	ON			ACEANDDATE	OF DISPO	SITION /NO	ime of	0007				City or To	
	1) Burial 2 Cremetio 4 Donetion 5 Other		oval from State	cemete P	ine Gro	ve C	emet	erv		4-				aryland
	21. SIGNATURE OF FUNERAL	SERVICE LIC	CENSEE					ND ADDRE	SS OF FA					
1	*	11	0/											al Home
_	saym	MI	Telen	ion		1	621	0pos	sumt	own	Pike/F	rede	rick	,Md.21702
	23. PART i. Enter the di	seases, or coart failure.	Complications the	t caused thuse on each	ne death. Do	not ente	r the mo	de of dy	ing, auc	h as ce	rdlec or reapid	ratory ar	reat,	Approximata interval Between
ı	IMMEDIATE CAUSE (Fin													Onset and Death
	disease or condition	→	· At	ner	050/2	roti	ch	tea	14	5.4	ease			3400
			DUE TO	(OR AS A CO	ONSEQUENCE O	F):					,	-		
2	Sequentially list conditi		b											
	if any, leading to immed	diate	DUE TO	(OR AS A CO	ONSEQUENCE O	F):								
HIFICATION	Cause. Enter UNDERLY! CAUSE (Disease or inju-		с											
=	that initiated eventa resulting in death) LAS		DUE TO	(OR AS A CO	ONSEQUENCE O	F):								
5 E	resulting in deatily Exis		d											
	PART il. Other significa	nt condition	a contributing to	death but	not reaulting	in the u	nderivin	g causa i	given in	Part i	24e. WAS AN	ALITOPSY	245	. WERE AUTOPSY FINDINGS
5								, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	3		PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
EDICAL	7.0	100	~ . ~								1 YES 2	NO		OF DEATH?
Σ	DID TOPACCO) lice o	Chitainite	TO	ALICE OF	DEAT	TLJ 14	EC -	116		J			1 TES 2 NO
HYSICIAN:	DID TOBACCO		CHIKIDUIE	10 0	AUSE OF	DEA								
2	EXAMINER?	MEDICAL	HOSPITAL:			OTHE		ACE OF D	EATH (Ch	eck only	one)			
2	1 TYES 2 NO		1 Inpatient 2			4 🗆 Nu		6 5 R	esidence	8 🗆 Otl	er (Specify)			
5	27. MANNER OF DEATH	Pending	26e. DATE OF (Month, D	lay, Year)	28b. TIA	JURY	WC	URY AT PRK?		28d. DI	EŞCRIBE HOW IN	JURY OC	CURED	
5		nveatigation				М		YES 2	NO					
2		Could not be	28e. PLACE O building,	etc. (Specify)	At home, ferm,	atreet, fec	tory, offic	•			CATION (Street a y or Town, State)	nd Numbe	r or Rural F	Route Number,
	4 Notificial	perermined												
2	290. CERTIFIER (Check only	IFYING PHYSI	CIAN: To the best of	my knowled	ge, death occum	ed at the	time, date	end place	, end due	to the c	euse(e) end man	ner as ats	ted.	
COMPLE														a) and manner as stated.
	29b. SIGNATURE AND TITUE	OF LEFTH BY	11 -					29r 110	ENSE NUI	WREE		284 DAT	e somen	(Morth, Dec. Year)
ŭ	/	7	N	-	de			D	11-4	28		≥ DM	41	1 91
2	30. NAME AND ADDRESS OF	PERSON WH	O COMPLETED CALL	SE OF DEATH	(ITEM 27) /5	Print)		-11	4	~0		_	71	1/7/
	Cline Caspe	- 67	HT. M.D.	700	11206	04	~	hees	6 -	21	erick	4.5	,	
	31. DATE FILED (Month Day,	Year)	12-1	R'S SIGNATI	IRE A	.75	>	reed	7	77 rd	erick	14	D	21701
	APR 1	7 199	5 julia	diwele	IRE PORTEL	A,								
	-T11 11 L	1 100				- 114								

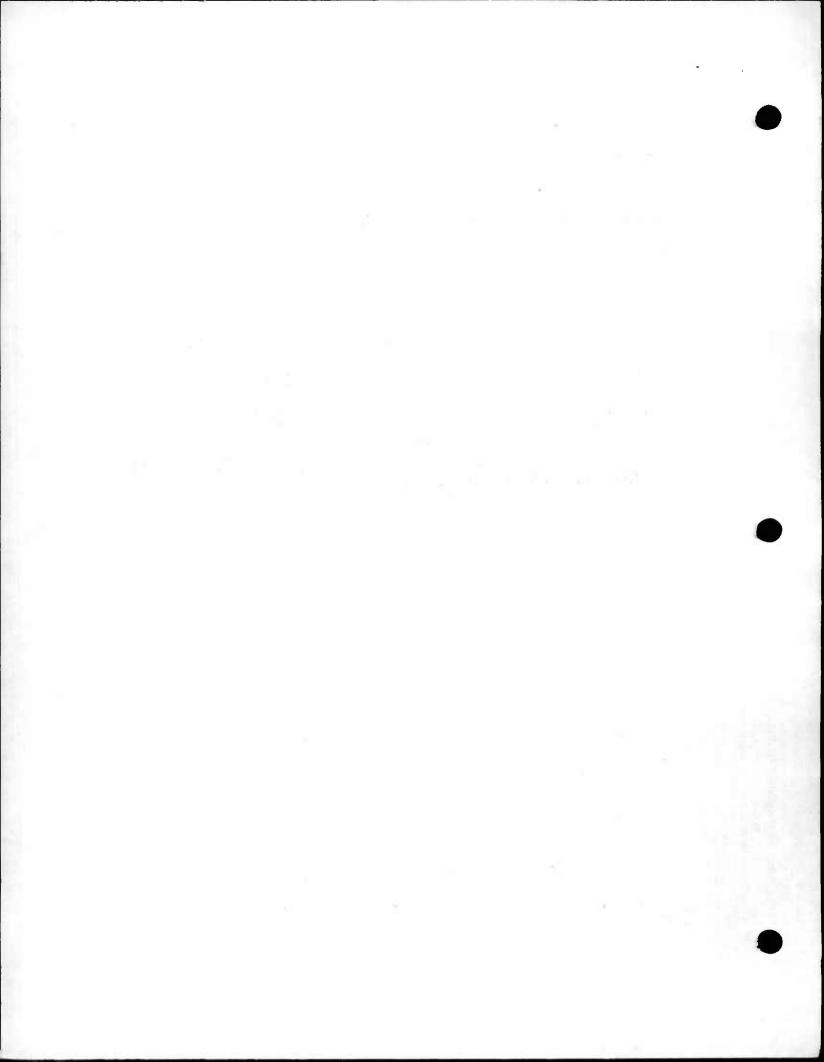


	1		1 - FOR STATE REGISTRAR		STATE OF N	MARYLA		DEPAR					MEN.	TAL HYGIEN			
			1. DECEDENT'S NAME (First	, Middle, Last)										TE OF DEATH			3. TIME OF DEATH
			Matilde	M. V	alerio								A	oril 1	3, 1	995	12:30P
			4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In		birthday)	IF UNDE	R 1 YEAR		DER 24 HRS,	7. DA	TE OF BIPTH		8. BIRTH Countr	PLACE (State or Foreign
	P		589- 09 - 237		1 🗆 M 2 🔀 F	73	3	YRS.	MONTHS	DAYS	HOUR	is min.	Ju	ne 3, 1	921		ippines
	3 should	œ	9a. FACILITY NAME (If not in						9b. CIT			ATION OF DE	EATH		9c. COU	NTY OF D	EATH
	1, 2, 3	0	12304 Brol	ass Rd.	Clinton	<u>n</u>					lint	con			Pri	nce	George
	sades	DIRECTO	10a. STATE	10b. COUNTY				10c. CITY			ATION						10d. INSIDE CITY
	permit. Pages		Maryland		e Georg	e's		C	lin	ton							LIMITS?
	t per	FUNERAL	100. STREET AND NUMBER		.d						IOF. ZIP C	^{∞0€} 2073!	5				HAT COUNTRY?
ian.	burial-transit	N	11. MARITAL STATUS													ippi	
020 physician.	burias		1 Never Married 2	Married	12. WAS DECEDEN' FORCES? 1 IF YES, GIVE W	YES	2XXNC		13.	If yes,	specify C	uban, Maxica	n, Puer	GtN? (Specify Ye to Rican, atc.)	s or No-	14. RACE Black	 American Indtan, White, atc.
215-0020 attending physic	s the	BY	3 Widowed 4 Divo	orced	IF TES, GIVE W	AH OH DAI	E 3		-	1 [] 1	es 2XX	NO Specify	γ:			Fili	pino
	use as			EDENT'S EDUCAT		1	6a. DEC	EDENT'S I e kind of w Do NOT use	USUAL C	OCCUPA during	TION most of wo	orkina		16b. KINO OF BU	SINESS/INC	_	-
21 vital or	d for use	الإ	Elementary/Secondary (0	1-12)	College (1-4 or 5+)		oo <i>not us</i> Iomem						λ÷	Home		
AND 21	detached once.	COMPLET	17. FATHER'S NAME (First, M	licicila I aath				Cancar	LUIC.	_	10.10	OT115010 A14	15.00				
MARYLAND 21 retained by the hospital or	3 K	m o	Pedro Maga									Nicola		st, Middle, Maider	Sumame)		
MAR	5 should be notified at	00	19a. INFORMANT'S NAME (1				19b.	MAILINO	ADDRES	S (Stree				Ruiz umber, City or Tov	rn, State. Zin	Code)	
N e reta	5	2	Danilo M. V	/alerio	(SON)		7	007	Per	ryw	boo	Road	, U	pper Ma	rlbor	o, N	d 20772
6 may be	8 2		4 □ Donation 5 □ Other	ION on 3 Ramov	al from State	20b. P	LACE AN	ND OATEO	ner place	Mann.	4-00	Aprıl v		,11995° LC			
Page 6 ma	of dire		21. SIGNATURE OF FUNERA						22.	. NAME	AND ADD	RESS OF FA	CILITY	Lee Fu	intor	Mar Hon	yland e,inc 66
BALTIM er death. Page	0 m 0		> Charle	le à	L. Bel	lang	en							rry Roa			n, Md
aft	d in by the or removal medical		23. PART I. Enter the d	Iseases, or con		caused t	ha daa		ot anta	r tha m	noda of	dying, suc	h as c	ardiac or resp	iratory arr	est,	Approximate
+ hours	BOE		IMMEDIATE CAUSE (Fir		only ona cau	se on eac	n iina.										Onset and D
The Co			disease or condition	→ a	_ Lu	us C	AI	VCR	R								SO MONT
760 ed wii	O = 0				DUE TO	OR AS A C	ONSEOL	JENCE OF):								
587 executed	sician and cor prior to burial, traumatic e	ON	Sequentially list conditi		DUE TO	(OR AS A C	ONSECI	IENCE OF	۸,								
o a	sician prior t	RTIFICATION	if any, leading to imme- cause. Enter UNDERLY!	ING	302.10	(OII 20 X 0	ONSEGO	PENCE OF	,.								
·	ther the	Ĕ	CAUSE (Disease or inju that initiated events	iry a.	DUE TO	(OR AS A C	ONSEOU	JENCE OF):								
	I Hyg	ERT	resulting in death) LAS	T d													
RDS, P	y the attend Mental	L CE	PART II. Other algnifica	nt conditions	contributing to	death but	not rai	auiting is	the u	ndarivi	na caus	e alven in	Part I	24a, WAS AN	AUTOBEV	1 245	WERE AUTOPSY FINDIN
F =	2 2	ICAL									ng ouds	e given iii		PERFO	RMED?	240.	AVAILABLE PRIOR TO COMPLETION OF CAUS
or # Sala	Health aws am	ED									-			1 TYES	DANG		OF DEATH?
L MECO	sh sh	Σ	DID TOBACCO U	SE CONTRII	BUTE TO CA	USE OF	DEAT	H YE	SП	NO I	J UN	NCERTAIN	V I				1 TYES 2 THO
he la	e has be te Dept.	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL				OF OEATI									
AN: T	certificate the State , or item	Sign	1 TES 2 NO		OSPITAL:	ER/Outpati	ent 3	DOA	OTHE	R: raing Ho	mo M	Rasidence	6 🗆 O	ther (Specify)			
ATTENDING PHYSICIAN: The	with th	F	27. MANNER OF DEATH Netural 5		26a. DATE OF (Month, De	INJURY ly, Year)		28b. TIME	OF	26c. 19	JURY AT		28d. [ESCRIBE HOW	NJURY OCC	URED	
NG PI	After this death with	B	2 Accident	Pending Investigation					M	1 🗆	YES 2	□ NO					
JENDIN C		G .		Could not be determined	28a. PLACE Of building, i	etc. (Specify,	At hom	e, farm, st	reet, fac	tory, off	lca		28f. L	OCATION (Street ity or Town, State)	and Number	or Rural A	oute Number,
DR AT	DIRECTOR: hours after Item 28 i	6								_			_				
	4 2 =	COMPL	(Check only		N: To the best of												
HOSPITAL	TO THE FUNERAL be filed within 72 IMPORTANT: If	8	-		On the oddle of as	1 /	O In	vestigation	i, in my c	opinion,	-			ata and place, ar	d dua to th	e cause(s)	and manner as state
뿔	S E E	띪	295. SIGNATURE AND TITLE	OF CENTIFIEN	1/	1//	V.	7			29c. L	CENSE NUM					(Month, Day, Year)
2	2 % ₹	0		////4	y V	Los	V					12033	2	_	- 4	1-/7	-70

PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

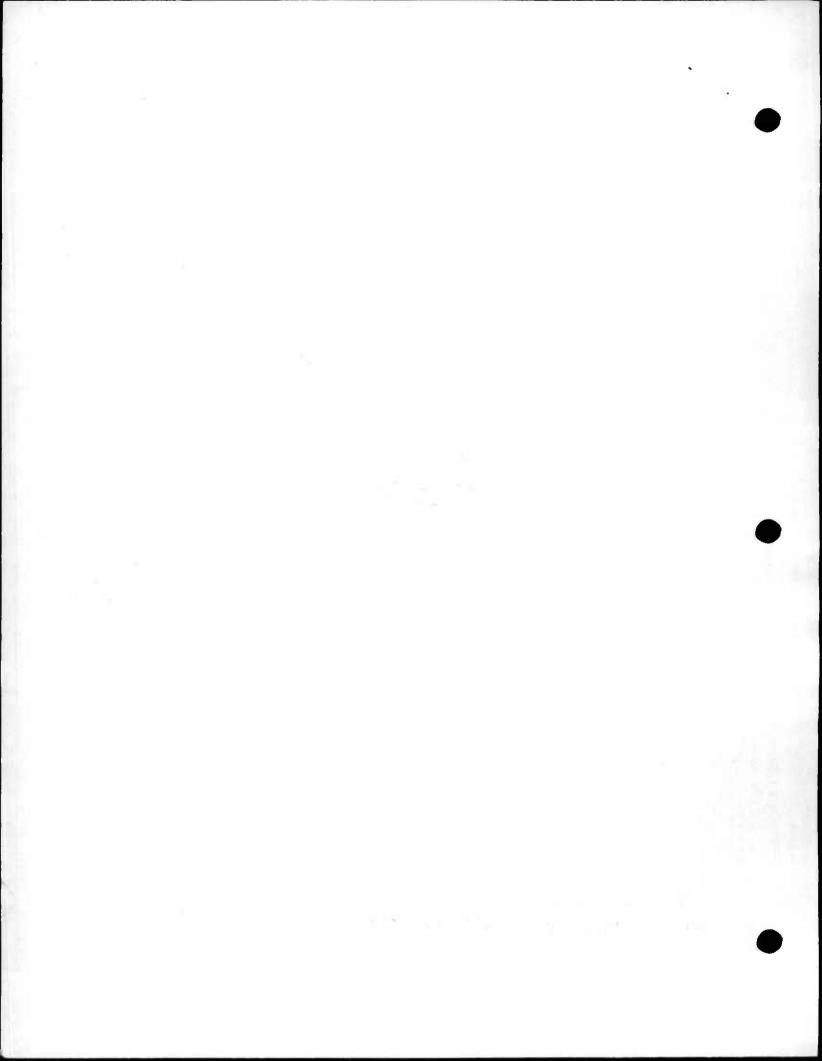
31. DATE FILED (Month, Day, Year) APR 1 8 1995

Harvey I. Katzen 8926 Woodyard Rd.# 201 Clinton, Maryland 20735



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BALTIN	HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pag	CINCOL DIOCTOD After this cardificate has been circust by the attending abusines and commission that to be decided di-
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	0	-
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	_	FOR 1 - STATE REGISTRAR	STATE OF MARYL		RTMENT OF H		MENTAL HYGIEI		
		1. DECEDENT'S NAME (First, Middle, Last	,				2. DATE OF DEATH		3. TIME OF DEATH
		Edgar George War					March 19.	1995	0411A M
		4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)
should		90. FACILITY NAME (If not institution, give	144	8) тнь.	ab CITY TOWN (OR LOCATION OF D	September 2		Pennsylvania
2, 3	DIRECTOR	Kent & Queen Anr		ospital	Chester		EATH	sc. COUNTY KE	of DEATH Int
ages 1	REC	10a. STATE 10b. COUN	(TY	10c. CIT	TY, TOWN OR LOCAT	TION			10d. INSIDE CITY LIMITS?
permit. Pages 1,	1 (Maryland	Kent		Chester				1 YES 2 NO
it pen	FUNERAL	100. STREET AND NUMBER 10731 Kosota Roa	ъ.Д		100	21620			OF WHAT COUNTRY?
physician. burial-transit	I B	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	N LIS ARMED	13 WAS DEC		NIC ORIGIN? (Specify Ye		States
priysi		1 Never Married 2 Merried	FORCES? 1X YES	2 NO	II yes, sp	ecity Cuban, Mexico 2 NO Specific	en, Puerlo Ricen, etc.)		RACE — American Indian, Black, White, etc. Specify:
as the	D BY	3 Widowed 4 Divorced				7.0	,		White
use a	TEO	15. DECEDENT'S ED (Specify only highest grad	ade completed)	(Give kind of	Work done during mo	ON ast of working	16b. KIND OF BU	USINESS/INDUST	RY
detached for once.	COMPLET	Elementery/Secondary (0-12)	College (1-4 or 5+)	Real F	Estate Br	olrer	Pos1	Estate	
e nos letachi	OM	17. FATHER'S NAME (First, Middle, Last)		WEGT T	State DI		AME (First, Middle, Melder		
at o	ш	William Oscar Wa	rner			Della W		n Surmenne)	
5 should be	10 B	19e. INFORMANT'S NAME (Type/Print)		19b, MAJLING	3 ADDRESS (Street a		Route Number, City or Tox	wn, Stete, Zip Cod	(o)
y be ref	F	Mrs. Frances War	ner	10731 I	Kosota Road	i, Chester	town, Marylan	nd 21620)
ector, pag		20e. METHOO OF DISPOSITION 1 Burlel 2 A Cremetion 3 Res			OF DISPOSITION (No			OCATION — City	
directi		4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L	Ca		natory Mar			er, Delaw	are
funeral funeral c			4 -/	UN	Fello	WS - Wel	кину 1s Funeral	1 Home	
the fu		William L. K		Munch	413 We	est High S	treet, Cheste	ertown, M	laryland 21620
24 hours after death. Page 6 may be retained by the hospital or attending physician filled in by the funeral director, page 5 should be detached for use as the burial-trainon, or removal. The medical examiner must be notified at once.		23. PART I. Enter the diseases, or ahock, or heart failure	r complications that caused e. List only one cause on ea	the death. De	not enter the mo-	de of dying, auc	h as cardiac or resp	plratory arrest,	Approximate
filled is fon, or the me		IMMEDIATE CAUSE (Final			1 1	10		7	Interval Between Onset and Death
_ = =		disease or condition resulting in death)	. Cardin	AC M	rrest	/Kesp	Utra	1t	MIN
	_		DUE TO (OR AS	CONSEQUENCE O	(F): /	11/			11 4
	No.	Sequentially list conditions,	b. DUE TO (OR AS A	CONSEQUENCE OF	PALL O	nillin			16 hrs
oearn certificate be executed attending physician and corental Hygiene prior to burial, iry, or other traumatic e	CAT	if any, leading to immediate cause. Enter UNDERLYING	. Ischen	(1	Alone	14 not	2.1		STVEARS
ing phy giene p	RTIFICATION	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF		1	1		
be dearn certificate be the attending physician Mental Hygiene prior to Jury, or other traun	ш	resulting in death) LAST	d			N			
E 8 5	ပ	PART II. Other algnificant condition	ons contributing to death b	out not resulting	in the underlying	cause given in	Part I. 24a, WAS AF	M ALITODSY	24b. WERE AUTOPSY FINDINGS
Z 2 2 Z	CAL					I canon Arreit	PERFO	PRMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE
OH ATTENDING PHYSICIAN: The law requires to DIRECTOR. After this certificate has been signed rours after death with the State Dept. of Health tem 28 is marked, or item 23 shows an	AEDI						1 TYES	2 140	OF DEATH?
as been Sept. of 23 sho	N.	DID TOBACCO USE CONT	TRIBUTE TO CAUSE O	F DEATH Y	ES INO X	UNCERTAIL	N []		1 YES 2 NO
references in the saw requires in this certificate has been signed with the State Dept. of Health rived, or item 23 shows an	CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF OEAT	TH (Check only one)				
or ite	YSICI	1 TES 2 NO	1 Vinpatient 2 ER/Outpa	intlent 3 DOA	OTHER: 4 Nursing Home	e 5 🗆 Residence	6 Other (Specify)		
his ce with the	РНУ	27. MANNER OF DEATH 1 Natural 5 Pending	(Month, Day, Year)	28b. TIM INJ	JURY WO	RK?	28d. OESCRIBE HOW	INJURY OCCURE	D
After this death with s marked	B	Accident Investigation				res 2 No			
TOR: A after d	8	3 Suicide 6 Could not be 4 Homicide determined	e building, etc. (Speci	— At home, lerm, : :#(y)	street, lectory, office	•	261. LOCATION (Street City or Town, State	and Number or Ru	ural Route Number,
DIRECTOR: After hours after death		290. CERTIFIER			material and the				
RAL D	COMPL	(Check only	SICIAN: To the best of my knowle						4 1 × 545 × 604 (1) (51 × 61 × 61
E FUNERAL E WITHIN 72 h		29b. SIGNATURE AND TITLE OF CERTIFI	NER: On the beele of examination	1 end/or investigation	on, in my opinion, or				
TO THE MUSPITAL OF THE FUNERAL DE DE FRE WITHIN 72 PAR IMPORTANT: IF IN	H	296. SIGNATURE AND TITLE OF CERTIFIE	0 0			29c. LICENSE NUI	WBER	29d. DATE SIG	NEO (Month, Day, Year)
2638	2	30. NAME AND ADDRESS OF PERSON W	VHO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type	Oriest)	DIOT	00	3-1	9-45
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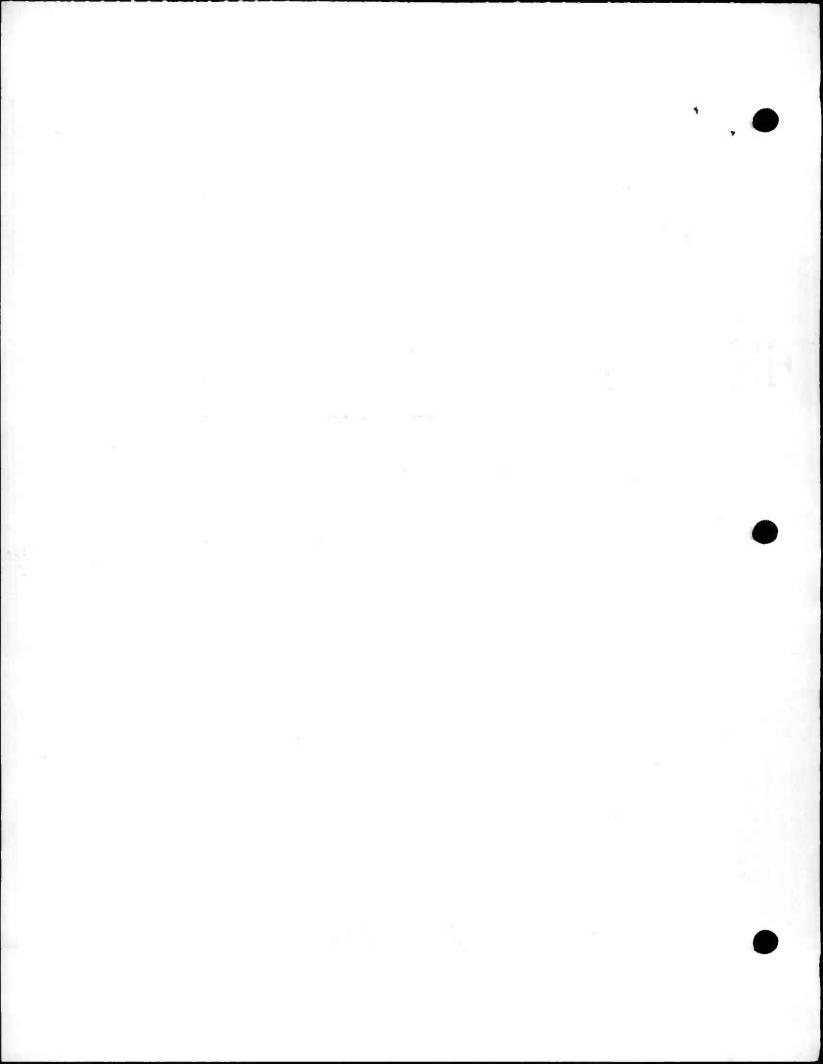
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	A ATTENDING PHYSICIAN: The law requires that the death certi

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

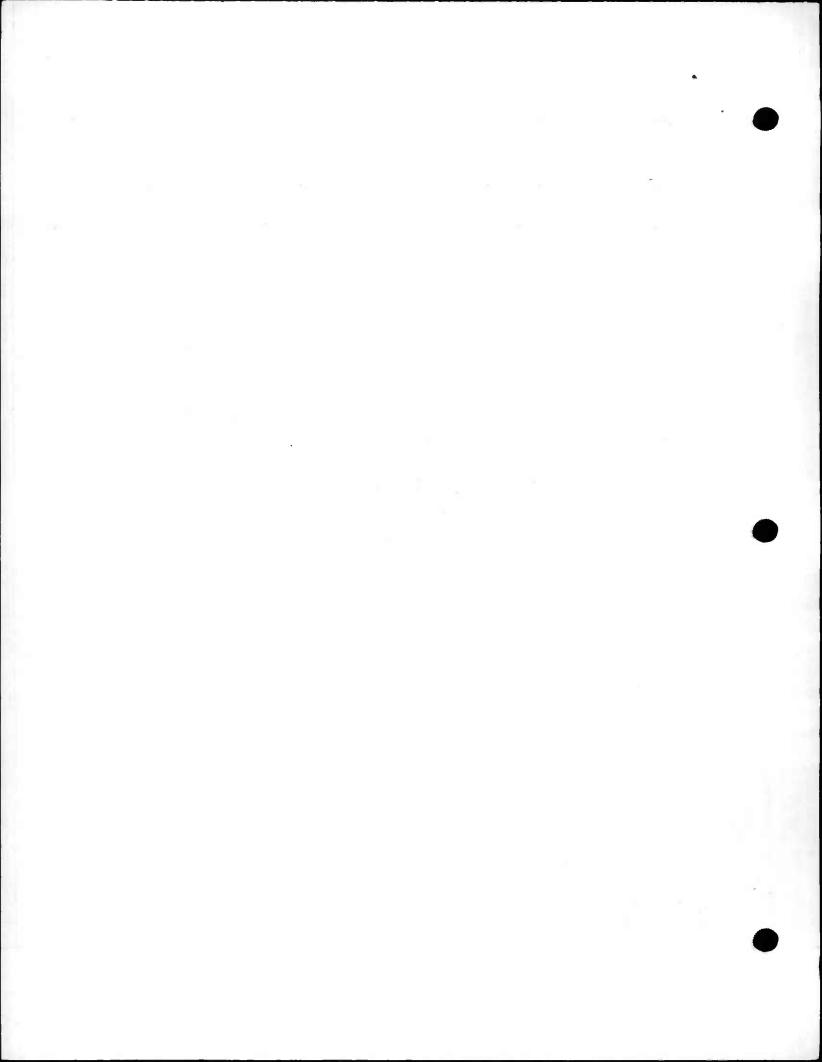
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	*	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH													3. TIME OF DEATH	
5.1		Mary Hill Wiltbank April 5, 1995 1605													1605 м	
*		4. SOCIAL SECURITY NUMBER				(In yrs. last birthday)			IF UNDER 1 YEAR		DER 24 HRS.	7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign		
. 1		216-38-9601				87 YRS.		MONTHS	DAYS	HOUR	S MIN.	May 9, 1	907	Ma	ryland	
	_	9a. FACILITY NAME (If not institution, give street and number)						9b. CIT	ry, towi	N OR LOC	ATION OF DE			JNTY OF DEATH		
	COMPLETED BY FUNERAL DIRECTOR	Kaufman's Care Home Kennedyville Kent														
		10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY												10d. INSIDE CITY		
		Maryland Kent						Kennedyville					LIMITS? 1 YES 2 X NO			
		10e. STREET AND NUMBER					10f. ZIP CODE					10g. CIT	IZEN OF	WHAT COUNTRY?		
		11951 Augustine Herman Highway									645		United States			
		11. MARITAL STATUS 1 Never Merried 2 Married FORCES? 1 YES			T EVER I	2 XNO			I. WAS D	ECENDEN'	T OF HISPAN	IIC ORIGIN? (Specify Y	, Puerto Rican, etc.)		4. RACE — American Indian, Black, White, etc.	
		3 🕅 Widowed 4 🗌 Divo	IF YES, GIVE V	WAR OR D	ATES		1 YES 2 NO Specify					Specify: White				
		15. DECEDENT'S EOUCATION (Specify only highest grade completed)					18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working					16b. KIND OF B	JSINESS/IN	DUSTRY	MITTLE	
		Elementary/Secondary (0-12)		College (1-4 or 5+)		life. Do NOT use		se retired.,	retired.)		rung					
ej		12 2				Teacher					_	Education				
t on		17. FATHER'S NAME (First, Middle, Last) Harry J. Hill										ME (First, Middle, Maiden Sumeme)				
eda	H	J - I I I I I I I I I I I I I I I I I I														
notif	2	Jane Kennedy					196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11604 Browntown Road, Kennedyville, Maryland 21645									
pe t		20a. METHOD OF DISPOSIT	ION		206	PLACEA	NDDATE	OF DISPO	SITION	Name of	-	OATE 20c I	OCATION -			
E		1 Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other	(Specify)		_ S	till"	Pony or o	ther place Cemet	tery	- Apr	il 8,	1995 Still	L Pond	Mary.	land	
al la		21. SIGNATURE OF FUNERA	L SERVICE LIC	ENTERNA	4	11	1	7 22	. NAME	ANO AOD	RESS OF FAC	CILITY	1 11			
af.		William L. King Jr. Fellows - Wells Funeral Home 413 West High Street, Chestertown, Maryland, 21620														
or removal. medical examiner must be notified at once.		23. PART I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, Approximate														
		IMMEDIATE CAUSE (Final Onset and Dasth														
at, cremation, event, the		disease or condition resulting in death) s. HUBER TENSIVE ARTERIOSCLEROTIC CARPIDUAS CULAR YEARS DUE TO (OR AS A CONSEQUENCE OF: 0.15 EASE														
- a	CERTIFICATION															
8 E		Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):														
r trat	S	CAUSE (Disease or Injury C. DEVERE ORGANIC BRAIN														
Hygiene or other		that initiated events DUE TO (OR AS A CONSÉQUENCE OF): resulting in death) LAST														
	E			d												
of Health and Mental shows any Injury,		PART II. Other significa	nt condition	s contributing to	death b	out not re	auiting	in tha u	inderly	ing caua	e givan in i	Part I. 24a. WAS A		246	WERE AUTOPSY FINDINGS	
amy	DICAL	- SHURAL DECL					UBITUS				10		PERFORMED?		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
of He	ME										_ /\			1 YES 2 NO		
23 Pg	AN	DID TOBACCO U		RIBUTE TO CA				_			CERTAIN	1 🗆 📗				
State Dept.	SCI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)														
e 5	HYSICI	27. MANNER OF DEATH		28a. DATE OF	INJURY	ontlant 3	28b. TIM	-	-	NJURY AT	7	8 Other (Specify) 28d. OESCRIBE HOW	INJURY OC	CUBED		
marked,	ВУ Р		Pending Investigation	(Month, O	ay, Year)	1		URY	٧	VORK? YES 2		200. OEQUINDE HOW	INSORT OC	CONED		
2 9		2 Accident 3 Suicide 8	— At hon	- At home, ferm, street, factory, office			281. LOCATION (Street and Number or Rural Route Number,									
n 28 l	E .	4 Homicide determined building, etc. (Specify)														
72 hours	4 1	29a. CERTIFIER (Check only	IFYING PHYSI	CIAN: To the bast of	my know	ladge, des	th occurre	d at the	time, da	ita end pla	ice, end dua	to the cause(e) and m	nner aa sta	ted.		
thin /	COM	one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(e) and menner se stated.														
be filed within	H	296. SIGNATURE AND TITLE	OF CERTIFIER	01.	01	0.	0			29c L	ICENSE NUM	BER	29d. DAT	E SIGNED	(Month, Day, Year)	
# B	ē.	30. HAME AND AGORESS OF	Ital	X /W	11	11	1)_	-		11	100	90/	1	6	75	
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		31. DATE FILED (Month, Days	Year)	32. REGISTRA	R'S SIGN	ATURE		1/6	0/0	810	wa,	1 Jury	una	0	7600	
		N	PD 13	<u>'d5</u>	Jul	lia Dai	ridson	- Pano	dell			Mary				

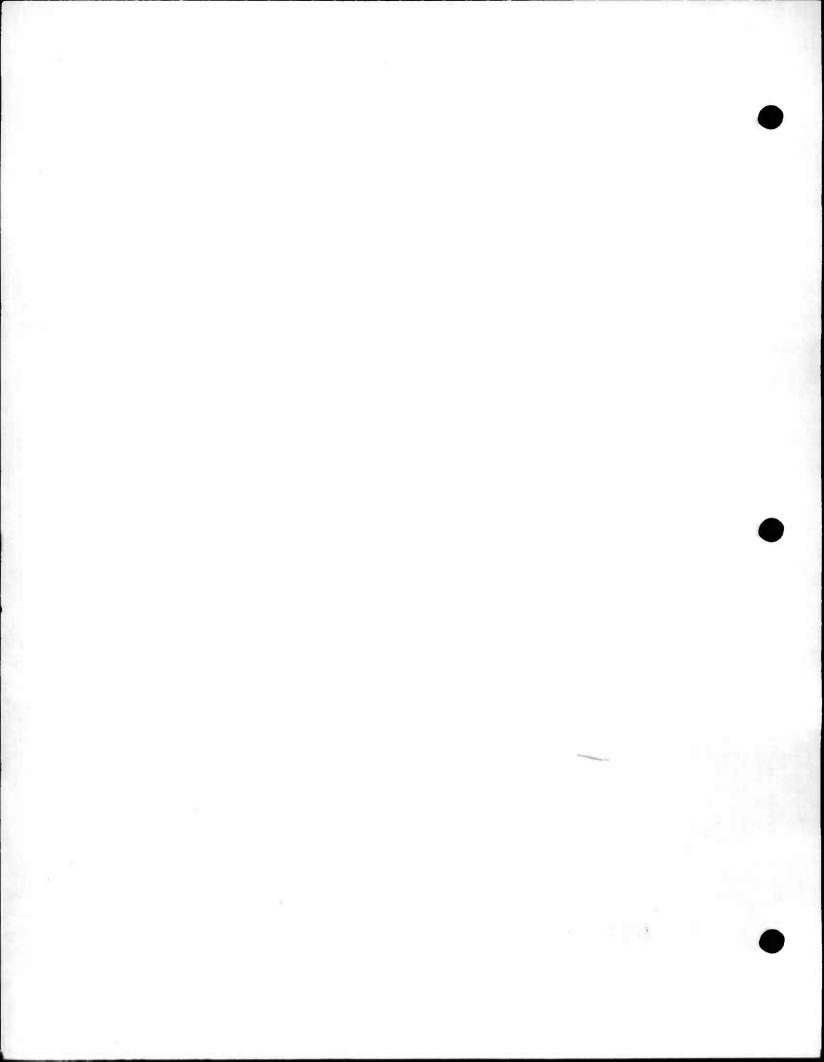


DIVISION OF VITAL RECORDS, P.O. BOX 68760

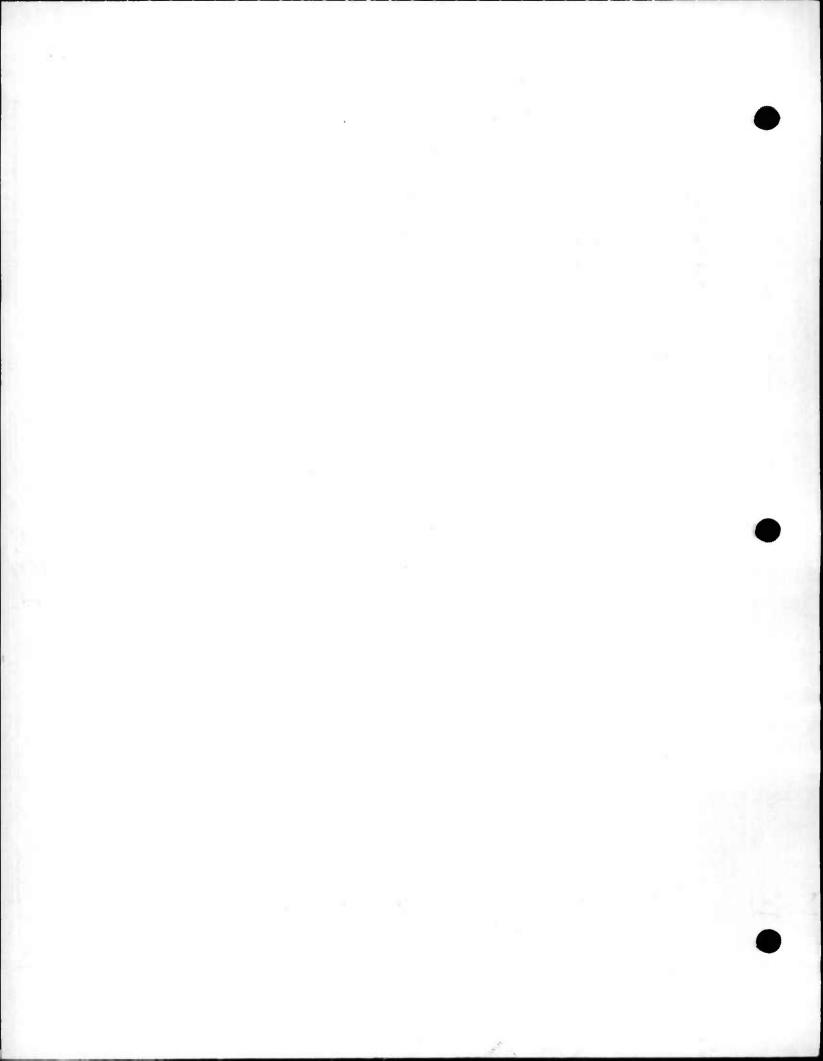
*	1 - STATE STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. OECEOENT'S NAME (First, Middle, Last)	2. DATE OF DEATH		3. TIME OF GEATH						
- 6	Mary Catherine Fogwell Willis			March 28,	, 1995 YEAR 7 AT					
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. In	7. DATE OF BIRTH (Month, Day, Year)	Co	IRTHPLACE (State or Foreign ountry)						
	161-14-1919 1 M 2X F 75 9a. FACILITY NAME (If not institution, give street and number)	YRS. MONT	1 2 200	April 3, 191		aryland				
Œ	11808 Augustine Hemman Highway (AT HOM		ITY, TOWN OR LOCATION OF DE		9c. COUNTY C	OF DEATH				
DIRECTOR	RESIDENCE OF DECEDENT	C /	Kennedyville	e	Kent					
RE	10e. STATE 10b. COUNTY	10c. CITY, TOW	N OR LOCATION		10d. INSIDE CITY LIMITS?					
	Maryland Kent	Kennedyville			1 TYES 2 NO					
FUNERAL	100. STREET AND NUMBER 11808 Augustine Herman Highway		101. ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?				
NE I	11. MARITAL STATUS 12 WAS DECEMENT EVER IN U.S. AL	RMFO	21645 13. WAS DECENDENT OF HISPAN	IC OBIGIN? (Specify Yea	United States					
	1 Never Merried 2 Married FORCES? 1 YES 2 F	7 90	If yee, specify Cuban, Mexican 1 YES 2 NO Specify	1, Puarto Rican, etc.)		Black, White, etc.				
Э ВУ	3 X Widowed 4 Divorced					hite				
COMPLETED	(Specify only highest grade completed) (C	ECEDENT'S USUAL Give kind of work do b. Do NOT use retire	ne during most of working	16b. KIND OF BUS	SINESS/INDUSTR	RY				
PLE	College (1-4 or 5+)	Clerk	0.,	U.S. Po	etal Co	rrico				
OM	17. FATHER'S NAME (First, Middle, Lest)	o z o z i c	18. MOTHER'S NAI	ME (First, Middle, Maiden		TVICE				
BE C	William F. Fogwell			atherine W						
TO B			ESS (Street and Number or Rural R)				
Mary Ann Gustafson 29054 River Road, Millington, Maryland 21651										
	20a_METHOO OF OISPOSITION 1XXBuriel 2 Cremetion 3 Removal from State	AND DATE OF DISI ematory or other pla	ce) cey - March 31,	DATE 20c. LO	CATION City o					
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	rong Lemen	22. NAME AND ADDRESS OF FAC	1995 Stil	l Pond, M	aryland				
	No. 11 11 11 11 11 11 11 11 11 11 11 11 11	1/1	Fellows - Wel	lls Funera						
_	William L. King Jr. 23. PART I. Enter the diseases, or complications that caused the de	1	413 West High S	treet, Cheste	ertown, M					
	ahock, or heart fallure. List only one cause on each list	e.	ter the mode of dying, auch	as cardiac or respi	retory arrest,	Approximate interval Between				
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)									
	resulting in death) a. DUE TO (OR AS A CONSE	OUENCE OF):								
Z	Sequentially list conditions (b.									
Ĕ	Sequentially list conditions, Due to (or as a consequence of): If any, leading to immediate cause. Enter UNDERLYING									
일	CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSE	OUENCE OF:								
CERTIFICATION	resulting in death) LAST									
	DADT II Coher elemificant conditions contribution to death but as									
PHYSICIAN: MEDICAL	PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE DE DESTRUCTION OF CAUSE DE DESTRICT.									
ED	avering - Previ Matiral Co	tral Carold cudarterectories 1 yes 2 no completion of cause of DEATH?								
Σ						1 TES 2 NO				
IAN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)									
Sic	EXAMINER? 1 YES 24 NO 1 Inpatient 2 ER/Outpatient 3	DOA 4 1	IER: Nursing Home 5 & Residence	8 Other (Specify)						
E	27. MANNER OF OEATH 28e. DATE OF INJURY (Month, Dey, Year)	28b. TIME OF	28c. INJURY AT WORK?	28d. OESCRIBE HOW IF	NJURY OCCURE	•				
Β¥	1 Netural 5 Pending 2 Accident Investigation	M	1 TYES 2 NO							
	3 Suicide 8 Could not be determined 28s. PLACE OF INJURY — At ho building, etc. (Specify)	ome, farm, atreet,	factory, office	281. LOCATION (Street a City or Town, State)	nd Number or Ru	rei Route Number,				
COMPLETED	290. CERTIFIER									
MP	(Check only CERTIFYING PHYSICIAN: To the best of my knowledge, de									
	The District of Contracts of Statistics and Statist									
H	Ca Dunaun		Doo3	29d. DATE SIGNED (Month, Day, Year)						
2	30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITE	M 27) (Type, Print)	1 1	<u> </u>		, 5., 13				
	C. Gottfried Baumann, M.D.	Che:	stertown.	Md. 21	1620					
8	31. OATE FILED (MOUN. Jan. 1607) 32. REGISTRAR'S SIGNATURE									
	MAR 37 95 Julia Davidson	-yandele								



		1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF I			HYGIENE REG. NO.			
			HIFFLETT		WATERFA	ALL	2. DATE OF MONTH	DEATH	YE,	AR	ME OF DEATH
Pin		4. SOCIAL SECURITY NUMBER 215-60-6375	1 □ M 2 💢 F 44	(In yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF FEB 2		4.0		CE (State or Foreign
1, 2, 3 should	TOR	ST. AGNES HOSPIT RESIDENCE OF DECEDENT				MORE CI		9	N/A		
Pages	DIRECTOR	Maryland Bal	timore	10c. CIT	Y, TOWN OR LOCA	TION Catonsvi	ille			V	INSIDE CITY LIMITS?
an. Iransit permit.	FUNERAL	965 Southridge Roa				7. ZIP CODE 21228			USA		COUNTRY?
215-0020 attending physician. use as the bunal-transit	BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR DA	2 XNO	If yes, sp	CENDENT OF HISPAI pecify Cuben, Mexica B 2 NO Specif	in, Puerto Ric			Black, Whi	merican Indian, ite, etc. Thite
21 for u	PLETED	15. DECEOENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) 12th	CATION completed) College (1-4 or 6+)	16a. DECEDENT'S (Give kind of life. Do NOT us	USUAL OCCUPATI work done during mi se retired.)	ON ost of working		ind of Busini			
क विक	BE COMPI	17. FATHER'S NAME (First, Middle, Lest) Edward Thomas Shifflett			18. MOTHER'S NAME (First, Middle, Meiden Surn. Gertrude Kwis			mame)	ame)		
E, MARYL y be retained by th age 5 should be o	TO B		196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) Robert Ewing Waterfall 965 Southridge Rd. Catonsville, MD 21228								
ALTIMORE, death. Page 6 may be tuneral director, page		20a. METHOD OF OISPOSITION 1	Mem	PLACE AND DATE	atory, I	Inc. $04/2$		Balti	imore,	, MD	
BALTIMOR ter death. Page 6 ma the tuneral director, p. wal.	ı	+ Dams.m	Donald		299	ation Soc Fredericl	k Rd.	Baltim	nore,	, In MD 2	c. 1228
within 24 hours after toletely filled in by the cremation, or removal rent, the medical		23. PART I. Enter the diseases, or conshock, or heart failure. LimmEDiATE CAUSE (Finei disease or condition resulting in death)	. IMIPRAMINE I	ech line.	ON	ode of dying, auc	h as cerdia	c or raapirat	ory arrest,		Approximate Interval Between Onset and Death
Executed n and con to burial, tmatic ex	TION	Sequentially list conditions, If any, leading to immediate		CONSEQUENCE O							
certificate ding physical hygiene pri	CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST oue TO (OR AS A CONSEQUENCE OF):									
at the d	JAL	PART II. Other algnificent conditions	contributing to death b	out not resulting	in the underlyin	g ceuse given in		PERFORME	107	AVAIL	E AUTOPSY FINDINGS LABLE PRIOR TO PLETION OF CAUSE
MEC v requires been sign t, of Hea shows	N: MEDIC	DID TOBACCO USE CONTR	BUTE TO CAUSE O	F DEATH YE	S NO E	UNCERTAIN		HES 2	NO		YES 2 NO
E se h	PHYSICIAN:		HOSPITAL: 1 ☐ Inpatient 2 X ER/Outp	26. PLACE OF OEA	OTHER: 4 \(Nursing Horizontal Actions of the control of the	ne 5 🗆 Residence	6 Other (S	Specify)			
R sit the B	ВУ РН	27. MANNER OF DEATH 1. Netural 5 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year) FOUND 4/25/9	5 UNKNO	WN M 1 □	PURY AT DRK? YES 2/(X) NO	UNKNO				
DIVIDION DIVIDING DIRECTOR: After hours after death lem 28 is ma	ETED	3 Suictde 6 Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, factory, of building, etc. (Specify)					CATONS	ON (Street end Town, State) 9 (lD	IDGE	lumber, RD .
□ Check only Ch										se(e) end	menner ee stated.
TO THE HOSPIT TO THE FUNER De filed within 7	29d. Date signed (29d. License number O. C. M. E. 29d. Date signed (APRIL 30. NAME AND APPRISON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)										
		JA PAN MONTH DON 1647 AT	WO RESULTED TO BE			reet, E	Balti	more,	Mar	ylan	d 21201
		APR 2 8 1995	danna danna								



	_	1 - STATE REGISTRAR	STATE OF MARY			F HEALTH		TAL HYGIEN REG. NO	E	
		1. DECEDENT'S NAME (First, Middle, Last	BELLE	WET	ZEL			TE OF DEATH DE	- Control	year 3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER 445-16-5001	10.00	GE (In yrs. last birthday)	IF UNDER 1 YE			TE OF BIRTN onth, Day, Year)	1	B. BIRTNPLACE (State or Foreign Country)
pine		9a. FACILITY NAME (If not institution, give	1 M 2 XXF	70 yrs.	200.00		Jul	y 31, 1		Missouri
, 3 should	S S	Suburban Hospi	2000			NN OR LOCATIO	ON OF DEATH			Y OF DEATH
s 1. 2,	ECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN				thesda			I Mo	ntgomery
. Pages	DIRE		ntgomery	10c. Cr	TY, TOWN OR LO					10d. INSIDE CITY LIMITS?
permit.	A.	10e. STREET AND NUMBER	regomery		Bethe	101. ZIP CODE			10g. CITIZI	1 YES 2 NO
ist.	FUNER	5012 Baltan Roa				2081			Unit	ed States
Z I 3-UU ZU attending physician. se as the burial-transit	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 YE IF YES, GIVE WAR OF	ES 2 X NO	2 X NO If yes, specify Cuban, Mexican, Puario Rica				s or No- 14. RACE — American Indian, Black, White, atc. Specify: White	
r attend	TED	15. DECEDENT'S ED (Specify only highest grad	UCATION de completed)	16a. DECEDENT'S	USUAL OCCUP	PATION g most of working	, 1	16b. KINO OF BUS	SINESS/INDU	
pital or	PLE.	Elementary/Secondary (0-12)	College (1-4 or 5+)	IIIe. Do NOT u	Iffe. Do NOT use retired.)					
the hospital or detached for u	COMPLET	17. FATNER'S NAME (First, Middle, Last)		Secr	Secretary 18. MOTNER'S NAME (First					Industry
# & & E	ш	Enos Curry					_	Alliste	,	
s retained 5 should notified	TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILIN	AOORESS (Str			umber, City or Tow		ode)
- 4 8 0		Leo E. Wetzel						an, Vir		
E F - TA		1 Burial 2XXCremation 3 Rei	moval from State	20b. PLACE AND DATE comelery, crematory or Montgomer	of Disposition	Pril.10	n, 1995 m; Inc.			ly or Town, Stata
Page 1		21. STONATURE OF FUNERAL SERVICE L	DENSEE /	Montgomen	22. NAM	E AND ADDRES	S OF FACILITY	Bet	nesda	, Maryland
exa fe		Mulan	C. Hoar	M0084	6 Chev	y Chase	e, Inc.	7557 4 7557	Wisco	me/Bethesda- nsin Avenue
E 3 4 B		23. PART I. Enter the diseases, or shock, or heart fallure	complications that course. List only one sector on	sed the death. Do	not enter the	mode of dyin	ng, such ea c	erdiac or reapi	ratory arrec	t, Approximata
ompletely fille or cremation, event, the		IMMEDIATE CAUSE (Final disease or condition resulting in death)	DUE TO (OR AS	S A CONSEQUENCE C	tructi	VE /L	nn	disea	IFE	interval Between Onset and Death
th certificate be executed by the state of t	ERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	· DEN	S A CONSEQUENCE O	N	scu	la	dice	ak	5 years
	AL C	PART II. Other algnificant condition	one contributing to deeth	but not resulting	In the underl	ying cause gi	lven in Part t.	24a. WAS AN		24b. WERE AUTOPSY FINDINGS
that that	MEDICAL	PERFORMED? 1 YES 2 TO COMPLETION OF CAUSE DF DEATH?							COMPLETION OF CAUSE	
10 0 0 0 1	AN:	DID TOBACCO USE CON	TRIBUTE TO CAUSE				RTAIN 🔼			MA
e ate	SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	26. PLACE OF OEA	TH (Check only o	one)				
icial certifi the	PHYS	27. MANNER OF DEATN	1 Inpatient 2 ER/O	Y 28b. TIN		INJURY AT		her (Specify) ESCRIBE HOW II	HIBY OCCIL	DED
NG PHYS fter this eath with	ВУ Р	Natural 5 Pending	(Month, Day, Year	·) in.	JURY	WORK?			-	ne.
TTENDI TDR: A after de	ED	3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF INJU building, etc. (S)	RY — At home, term, pecify)	street, lectory, o	office	28f. LC	OCATION (Street a ity or Town, State)	nd Number or	Rural Route Number,
	MPLET		SICIAN: To the best of my known							
THE HOSPITAL THE FUNERAL flied within 72 PORTANT: It	S	2 MEDICAL EXAMIN		tion and/or investigation	on, in my opinio	n, death occured	d at the time, di	ata and placa, and	d due to the	cause(a) and manner as stated.
물 물 물 등	BE	296. SIGNATURE AND TITLE OF CHATIFU	Show WAS	ATTEN	SING	29c. LICEN	ISE NUMBER		29d. DATE S	HGNED (Month, Day, Year)
₽₽3₹	2	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF	DEATN (ITEM 27) (Type	Print)	103	166		7	-7-75
51		JOHN E YER	TOMO 5			que n	Was	484 0	C 21	3/00
		31. DATE FILED (Month, Day, Year) APR 11 1995	July 22 REGISTRAR'S S	Indally			011	, , , ,		



Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. or Health and Mental Hygiene prior to burial, cremation, or removal. hours after death. Page 6 may be retained by the hospital or attending physician. notified at once. Pe must examiner cremation, or removal the medical DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within event, traumatic injury, or other shows any has b 23 certificate to the State 6 this c marked, After t .09 DIRECTOR: / 28 TO THE HOSPITAL D TO THE FUNERAL DI be filed within 72 ho IMPORTANT: It Ite

BY

COMPLETED

BE

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											95)	
	1 - FOR STATE REGISTRAR	STATE OF	MARYLAND / [Cei	DEPAR RTIF	TMEN	OF F	IEALTH DEA	AND TH	MENTAL	HYGIE REG. N			
Tarbella I	1. DECEDENT'S NAME (First	The state of the s	Wardell						2. DATE O MONTH April		1 995	YEAR	
	4. SOCIAL SECURITY NUM 577-03-22		6. AGE (In yrs. lest b	virthday)	IF UNDER	DAYS	# UNDE	MIN.	7. DATE O	F BIRTH Day, Year)		8. BIRTH Count Eng	m
	90. FACILITY NAME (W rot H	nstitution, give street and number) ie Drive				thes	on LOCATI			<u>:</u>		NTY OF C	DE
1	RESIDENCE OF DE												_
ı	Maryland	Montgomery			v, rown o		TION						

3. TIME OF DEATH 3:30 PLACE (State or Foreign land EATH DIRECTOR ery 10d, INSIDE CITY 1 YES 24 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6303 Carnegie Drive 20817 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE -- American Indian, Black, White, atc. 1 Never Married 2 K Married If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: BY Specify: 3 Widowed 4 Divorced WW II White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) 12 Tax Auditor IRS 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) Ernest Wardell Kathleen Browne BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Ethel C. Wardell 6303 Carnegie Drive, Bethesda, Maryland 20817 20s, METHOD OF DISPOSITION

1 🖾 Burlel 2 🗆 Cremetton 3 🗆 Re
4 🗆 Donation 5 🗀 Other (Specify) ____ 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE Fort Lincoln Cemetery 4/13 Brentwood, Maryland 21. SIGNATURE OF FUNERAL SEMINCE LICENSEE 22. NAME AND ADDRESS OF FACILITYHines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac gr reepiratory arrest, Approximata shock, or heart fellure. List only one ceuse on Interval Batwe IMMEDIATE CAUSE (Finel Onset and Death disease or condition resulting in death) ears DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY 1 TEB 2 OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only EXAMINER? HOSPITAL et 2 C ER/Out 6 D Other (Specify) 27, MANNER OF DEATH 28a, DATE OF INJURY (Month, Day, Year) 28d. DESCRIBE HOW INJURY OCCURED 1 Natural M

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. and/or in estigation, in my opinio

п,	Death occured at t	ne time, dete	and place,	and dua	to the	cause(s)	and manner	as state
_	29¢ LICENSE N	HIMBED		204	DATE	ALCOHO.	/4.4	M and

008736

1 YES

NAME AND ADDITES OF	PERSON WHO	COMPLETED CAUSE	OF DEATH (LEM 27) (From Print)	_
v /	04401	0101	RADA	RETAIN	1

32 REGISTRAR'S MONATUS

28s, PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify)

31. DATE FILED (Month, Day, Year) APR 12 1995

Accident

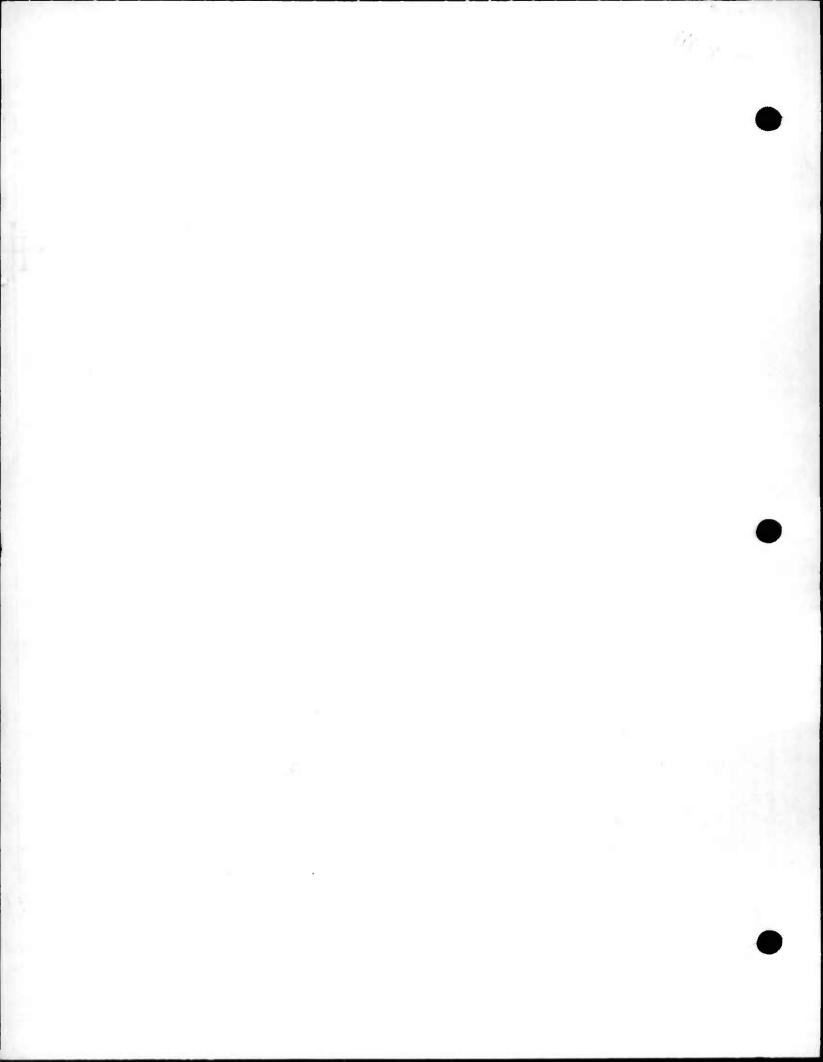
a Could not be

datarmined

3 Suicide

29a. CERTIFIER

4 Homicide

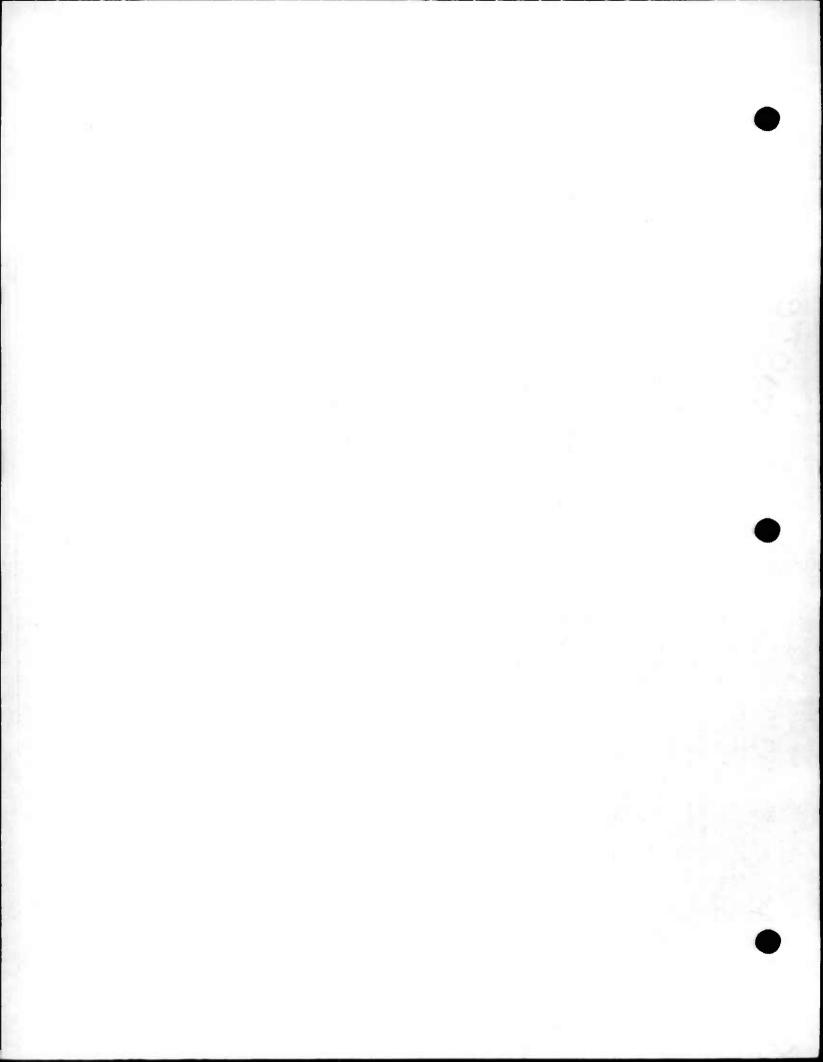


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BALTIMORE	
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pag		
lospital or attending	ched for use as the		
be retained by the h	ge 5 should be deta		
r death. Page 6 may	e funeral director, pa	je j	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within exhours after death. Page 6 may be retained by the hospital or attending physician.	npletely filled in by th	cremation, or remov	
artificate be executed	ng physician and con	giene prior to burial,	
res that the death ce	igned by the attendi	lealth and Mental Hy	
SICIAN: The law regu	certificate has been	the State Dept. of H	
OR ATTENDING PHYS	IRECTOR: After this	ours after death with	
TO THE HOSPITAL (TO THE FUNERAL D	be filed within 72 ht	

		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMENT OF	HEALTH AND F DEATH	MENTAL HYGIEI			
		1. DECEDENT'S NAME (First, Middle, Last) WANNEGHT					2. DATE OF DEATH	766	"	TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. lest birthday)		The second section of the last terms of the last	7. DATE OF BIRTH (Month, Day, Mear)	00	BIRTHPLA Country)	GE (State or Foreign
		210-10-1153	1 🗆 M 2 💢 F	83 YRS.	MONTHS DAY		Nov. 21,	1911		ylvania
	œ	9a. FACILITY NAME (If not institution, give				N OR LOCATION OF D	EATH		TY OF BEAT	
	ဠ	Holy Cross Hospi			SIIVE	r Spring		Mon	tgome	ry
	DIRECTOR	10a. STATE 10b. COUNT			TY, TOWN OR LO				100	I. INSIDE CITY LIMITS?
		Maryland Mont	gomery	Ke	nsingto	10f. ZIP CODE		44 - 01717		YES 2 NO
	FUNERAL	3000 McCommas Ave	enue			20895			USA	COUNTRY
	5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS 0	ECENDENT OF HISPA	NIC ORIGIN? (Specify Ye		4. BACE -	American Indian,
	BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA			ES 2 X NO Speci	en, Puerto Rican, etc.)		Specify:	124200
		15. DECEDENT'S EDU	JCATION	16e. DECEDENT'S	USUAL OCCUPA	TION	16b, KIND OF BU	JSINESS/INDU	STRY	White
		(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT u	work done during use retired.)	most of working				
8	COMPLET	12	4	Home	maker			Home		
at once.	႘	17. FATHER'S NAME (First, Middle, Last)				1 .	AME (First, Middle, Maide			
fled	8	Charles Rinard 190. INFORMANT'S NAME (Type/Print)		19b. MAILIN	G ADORESS (Street	Unknow	An Ur (opp	Parfe)	
not a	2	Charles E. Wainwr	ight							land 20905
examiner must be notified at		20a. METHOD OF DISPOSITION 1 ☐ Burlel 2 ※ Cremation 3 ☐ Rem	noval from State 20b.	PLACE AND DATE	OF DISPOSITION	Name of	DATE 20c. L	OCATION — CI	ity or Town,	State
E		4 Donation 6 Other (Specify)	Fo	ort Line						ryland
amin		In signal one of Folicial Service En	2 Di an'		118	00 New Ha	mpshire Av	renue		eral Home
odical ex		Jaine of	Millyss		Sil	ver Sprin	g, Marylar	nd 209		
medical			List only one ceuse on a	ech line.	not enter the r	node of dying, suc	ch as cerdiac or reap	olratory arre	st,	Approximats Interval Between
a		IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Cardi	olulu	wnai	4 Arra	22/			Onset and Death
event,		resolding in death)	OUE TO (OR AS A	CONSEQUENCE	OF):				-1	to analy
natic e	S O	Sequentially list conditions,	b. DUE TO OR AS A	tony) fue	who	y			yays
traem	YAT	If any, lesding to immediate cause. Enter UNDERLYING	Change	(A CT	tare.	Lulmono	yy The	me	_ /	425.
ther	Ĕ	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):								- 1.
, or	CERTIFICATION	resulting in death) LAST 1 Very afor Reperdent 1 TUK						TWK		
	CALC	PART II. Other significent condition	ns contributing to death be	ut not reaulting	In the underly	ing ceuse given in				RE AUTOPSY FINDINGS
4 5		Swall 19	A	matric	57)		PERFO	2 NO	CON	ILABLE PRIOR TO WPLETION OF CAUSE DEATH?
	MEDI	1 very are	ition					1		YES 2 NO
item 23 s	PHYSICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL		F DEATH Y			N 🗆			
item	SIC	EXAMINER?	HØSPITAL:		OTHER:	ome 5 - Residence	A C Other (Constitution			
, o	¥ I	27. MANNER OF BEATH	/ 28e. DATE DF INJURY (Month, Day, Year)	28b. TIR	ME OF 28c.	NJURY AT	28d. DESCRIBE HOW	INJURY OCCU	RED	
	8	1 Natural 5 Pending 2 Accident Investigation	(month, pay, roal)		4.0	YES 2 NO				
28 is	ا ه	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY building, etc. (Speci	— At home, ferm,	street, fectory, of	fice	261. LOCATION (Street City or Town, State	end Number of	r Rural Route	Number,
Item 2		29e. CERTIFIER		an Hen	-7,0		<u> </u>			
7 1	COMPL		ER: On the basis of examination							t manner on stated
>	<u>u</u>	296. SIGNATURE AND JULE OF CENTRE				29c. LICENSE NU				nth, Day, Ybar)
MP	∞	Mehypa	Nus			1)-3	1332	D 64	106	95
]	2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type	Prine)	ts 220	Charles Co		1	2 2012
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SON	ATURES /	Jule 1		muer sp	my /	ver -	100(02
		APR 101995 A	fally diaudion has	ball						l



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BALTIMORE, MARYLAND 21215-0020	
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

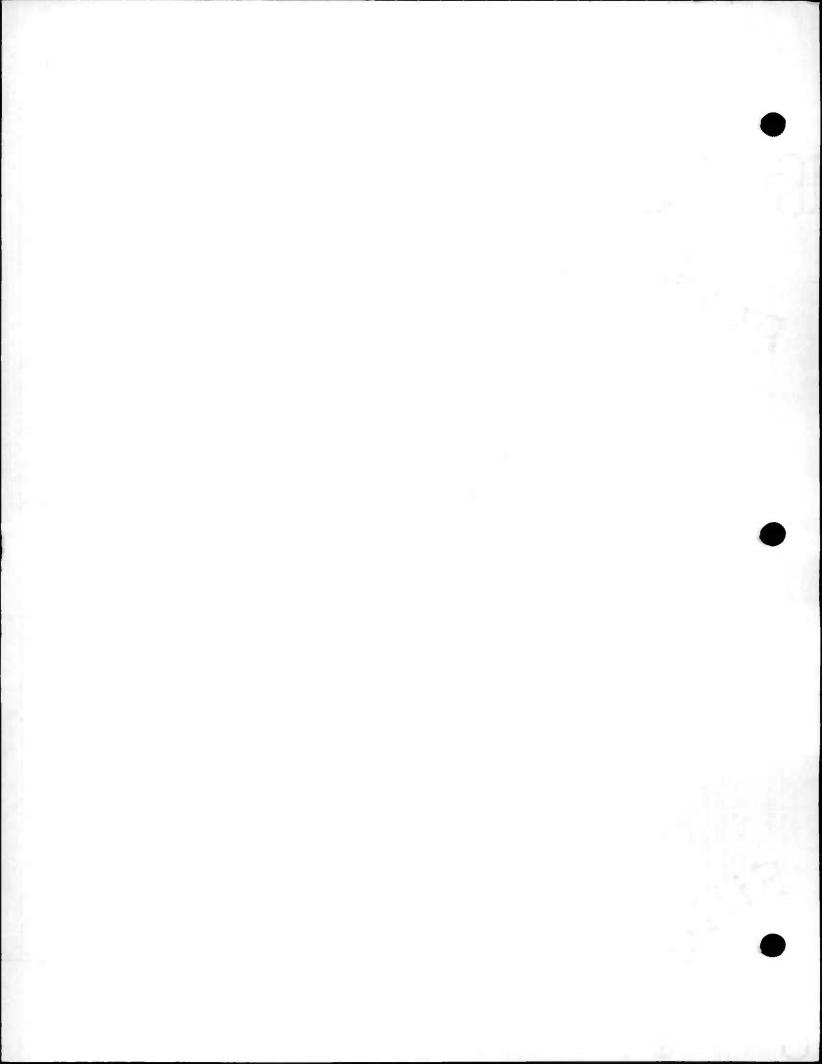
VSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Deor, of Health and Mental Hydiene prior to burial, cremation or removal.	sd, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by it be filed within 72 hours after death with the State Degr. of Health and Mental Hydiene prior to burial, cremation or remove	MPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, t

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH

1. DECEMPATY'S NAME (First Middle Least)

_	nedis i nan				CL	MI II	ICALL	UF	DEAL	111		REG. NO.				
	1. DECEDENT'S NAME (First,										2. DAT	TE OF DEATH	ν.	YEAR	3. TIME OF DEATH	
	DIA		S.	W								2:00 PM				
	4. SOCIAL SECURITY NUMB		5. SEX		in yrs. lest i	birthday)	IF UNDER	DAYS	IF UNDER	24 HRS.	(Ma	E OF BIRTH with, Day, Year)		Count	8. BIRTHPLACE (State or Foreign Country)	
1 8	212-64-789	92	1 M 2 K F		41	YRS.	-ONTHS	June 29, 1953			Was	hington, D.C				
	9a. FACILITY NAME (If not in	stitution, give	street end number)				9b. CITY	, TOWN	R LOCATIO	ON OF DE	EATH		9c. COL	JNTY OF D	PEATH	
DIRECTOR	605 Bromle	y Stre	eet					Silver Spring Montgom				nery				
ן קַן	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY					10.00	W 2000	TOWN OR LOCATION								
E					- 1										10d. INSIDE CITY LIMITS?	
	Maryland	Me	ontgomery			Silver Spring						1 YES 2 NO				
FUNERAL	605 Bromley Street					10f, ZIP CODE			10g. CITIZEN OF WHAT							
N N	11. MARITAL STATUS	y Stre	12. WAS DECEDEN				1			902				U.S.		
	1 Never Married 2 🔀	Married	FORCES? 1	YES	2 X NC			If yes, sp	ecity Cube	n, Mexica	n, Puert	GIN? (Specify Yes to Rican, etc.)	or No-	14. RACI Blac	E — American Indian, k, White, etc.	
B	3 Widowed 4 Divo	rced	IF YES, GIVE V	MAR OR DA	ATES			1 TYES	2 📉 NO	Specify	y:			Spec	White	
0	15. DEC	EDENT'S EDU	JCATION		16a. OEC	EDENT'S	USUAL O	CCUPATIO	ON		1	8b. KIND OF BUS	INESS/IN	DUSTRY	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
COMPLETED	(Specify only Elementary/Secondary (0	y highest grad	completed) College (1-4 or 5		(Give	e kind of v	vork done le retired.)	during mo	st of workin	ng	- 1	oc. raito or boo	WEDD/ 114	DOSTRI		
딥	12	·	College (I-4 b) 3	"	Cro	ssi	ng G	uard			M	font gome	rv (Co. F	Police Dept.	
O	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)						office Bept.									
	Charles Meil	Le								en L						
BE	19a, INFORMANT'S NAME (7)	ype/Print)			196.	MAILINO	ADDRES	S (Street e					State 7	in Codel		
2	P 19a. INFORMANT'S NAME (Type/Print) William Winpisinger 19b. MAILINO ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 605 Bromley Street, Silver Spring, Marylar							and 20902								
	20aL METHOD OF DISPOSITI	ION		20b.	PLACEAN	ID DATE	OF DISPOS	SITION /Na	me of		-	ATE 20c. LO				
	1 ☐ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		noval from State	Gen	ate crem	Pry or	eave	n Ce	mete	ry	4/				g, Maryland	
1 1	21. SIGNATURE OF FUNERAL	L SERVICE L	CENSEN	- 11							1 '				neral Home	
1 1	> X/4/	.11	Vin. A.	/ .			1	1800	New	Ham	psh	ire Ave	nue		illerar itolie	
Н	23. PART I. Enter the di	10x	cuava	1		-	S	ilve	r Sp	ring	, M	aryland	. 20	904		
	shock, of heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):															
ATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING															
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST															
	PART II. Other algnifice	nt conditio	na contributing to	death h	ut not re	eultlaa	n the u	dodulo		-luca la	Don't	T		L		
MEDICAL			tie contributing to	Goddi Di	dt not le	sulting (iii tile til	ideriyini	ceuse ç	liven in	Part I.	24a. WAS AN PERFOR		246	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
							_					1 YES 2	NO NO		COMPLETION OF CAUSE OF DEATH?	
- I									_						1 TES 2 NO	
AN	25. WAS CASE REFERRED TO	MEDICAL														
힐	EXAMINER?	MEDICAL	HOSPITAL:	ATAU	69.1		OTHE	R:	ACE OF O							
PHYSICIAN:	1 YES 2 NO		1 Inpatient 2 I				_	_		sidence		her (Specify)				
ВУ Р	Natural 5 1	Pending Investigation	(Month, E	Pay, Year)			M	1 🗆 1	RK7 rES 2) NO		EŞCRIBE HOW IN	100			
ETED		Could not be determined	28e. PLACE C building,	stc. (Spec	— Al nom	e, farm, s	Rreet, fact	tory, offic				OCATION (Street e ity or Town, State)	nd Numbe	r or Rumi i	Route Number,	
COMPLET			ER: On the best of												e) end manner ee stated,	
BE	29b. SIGNATURE AND TITLE	OF CERTIFIE	Roll		MS	Q.				0796					(Month, Day, Year) 5, 1995	
임	30. NAME AND ADDRESS OF	PERSON WI	O COMPLETED CAU	SE OF DE	ATH (ITEM	27) (Туре,	Print)			0,00	,		I			
	Albert E. 31. DATE FILED (MONTH) Day, APR 10	Rolle 195 /	M.D. 38	00 R	eser	voir	Roa	d, 1	V.W.,	Was	shin	igton, I).C.	200	007	
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REG. NO

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

2. DATE OF DEATN 3. TIME OF DEATH April 7, 1995^{EAR} 10:48 p. w Charles Edward Williams 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH B. BIRTHPLACE (State or Foreign April 27, 1938 1 X M 2 | F 61 Wash. DC 214-30-0470 pinous 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH funeral director, page 5 should be detached for use as the bunial-transit permit, Pages 1, 2, 3 DIRECTOR PRINCE GEORGES Laurel Regional Hospital Laurel RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Prince Georges Laurel 1 1 YES 2 | NO 10e. STREET AND NUMBER FUNERAL 10f, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 8508 Lindendale Drive 20707 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ∑ YES 2 □ NO IF YES, GIVE WAS OR DATES 11. MARITAL STATUS 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, alc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 X Married 1 YES 2 NO Specify: В Specify: 3 Wildowed 4 Divorced Black 16a. DECEDENT'S USUAL OCCUPATION

16a. DECEDENT'S USUAL OCCUPATION

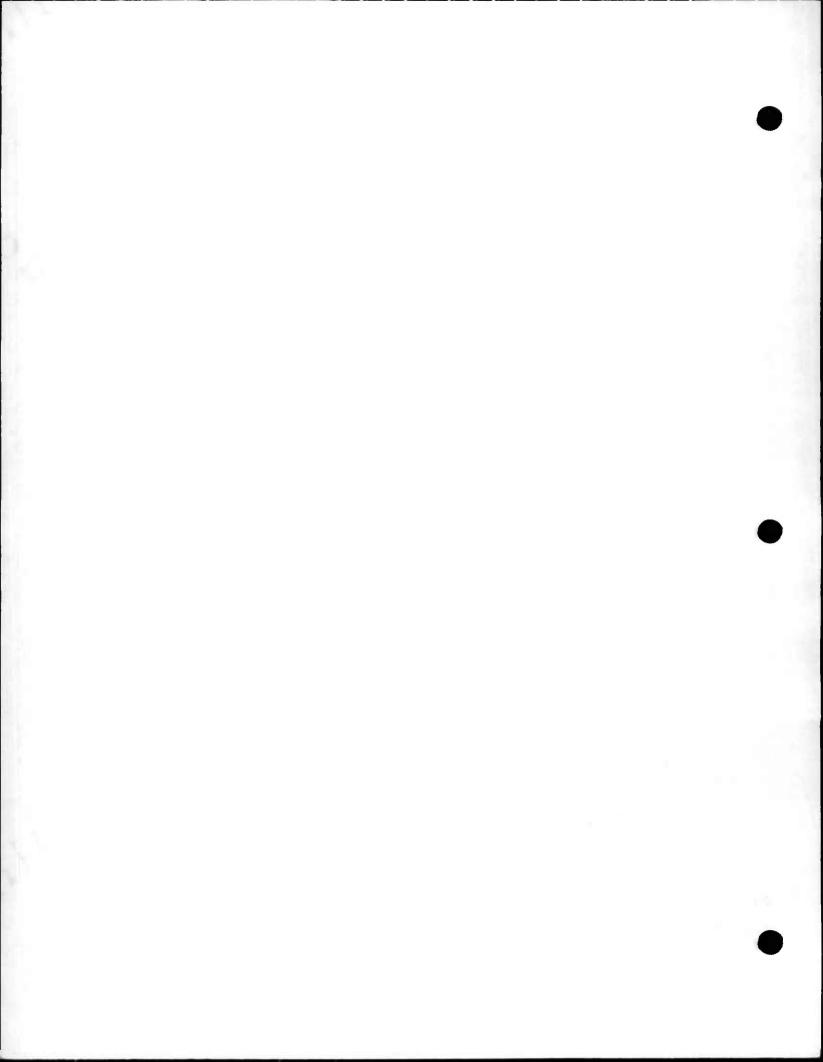
16a. DECEDENT'S USUAL OCCUPATION

16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) Collega (1-4 or 5+) 12th Metro Rail Train Operator notified at once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Ambrose Williams Lena Herbert BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 8508 Lindendale Dr., Laurel, MD 20707 Williams (Wife) Mattie L. 90 20a. METNOD OF DISPOSITION
1 X Burial 2 Cremation 3 F
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must 3 🗆 Rer "Nat" I'm Mem. Park Macron Laurel, MD examiner 21. SIGNATURE OF FUNERAL SERVICE UCENSEE 22. NAME AND ADDRESS OF FACILITY
SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, the MD or removal. event, the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory street, shock, or heart feliure. List only one ceuse on each line. been signed by the attending physician and completely filled in by it of Health and Mental Hygiene prior to burial, cremation, or remo Approximats Interval Between IMMEDIATE CAUSE (Finel Onset and Death disease or condition resulting in death) UMMA HENCE OF): OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO (OR AS A CONSEC traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): Cl CAUSE (Disease or injury other thet initiated events reaulting in deeth) LAST injury, or PART II. Other algolificent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? memorias shows any 1 TYES 2 THE 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: has by Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) Hell certificate I HOSPITAL:
15 inpetiant 2 ER/Outpetiant 3 DOA OTHER: 1 YES 2-1 NO 4 Nursing Home 5 Residence 6 Other (Specify) 6 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED this c marked, Natural 5 Pending 1 YES 2 NO В After t Accident 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED. .00 8 Could not be DIRECTOR: / 4 Nomicide 28 datarmined 29a. CERTIFIER CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

MEDICAL EXAMINER: On the best of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the co COMPL TO THE HOSPITAL O TO THE FUNERAL DI be filed within 72 ho IMPORTANT: It ite (Check only one) restigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and mennar as stated. 291. SIGNATURE AND TITLE OF ES 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE 95 8 WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 2 30. NAME AND ADDRESS OF PERSON 20 31. DATE FILED (Month, Day, Year)
APR 12 1995 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



FOR STATE REGISTRAR

4. SOCIAL SECURITY NUMBER

1. DECEDENT'S NAME (First, Middle, Last)

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119-18-2832 1 M 2 X F 92 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give atreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 604 POPLAR WOOD PLACE GAITHERSBURG RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND MONTGOMERY CHEVY CHASE permit. 10a. STREET AND NUMBER FUNERAL 10f. ZIP COOE 3312 BROOKLAWN TERRACE funeral director, page 5 should be detached for use as the burial-transit 20815 Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yaa or No—
If yes, specify Cuban, Maxican, Puerto Rican, stc.)
1 YES 2 NO Specify: 11 MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY 3 📉 Widowed 4 🗌 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a, DECEOENT'S USUAL OCCUPATION ive kind of work done Do NOT use retired.) est of working Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) "UNKNOWN" Ħ PUKLER "UNKNOWN" BE notified a 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 ERNEST WEISS (SON) 3312 BROOKLAWN TERRACE, CHEVY CHASE, MD 20815 pe 29a. METHOD OF DISPOSITION 1 District 2 X Cremation 20b. PLACE AND OATE OF DISPOSITION (Name of DATE must MT COMFORT CREMATORY 4 Donation 5 D Ott 4/14 examiner 21. SIGNATURE OF FUNERAL 22. NAME AND ADDRESS OF FACILITY hours after death. the medical 23. PART I. Enter the diseases, in complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or raspiratory errest, attock, or heart failure. List only one cause on each line. filled in by cremation, or **IMMEDIATE CAUSE (Final** the disease or condition SEPSIS executed within 24 and completely fi to burial, cremation resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF):
LCRAL DECUBITUS ULCER SACRAL traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 been signed by the attending physician and Health and Mental Hygiene prior to If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST ö Injury. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL ZHEIMERIS DISTASE that any requires shows : DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\overline{\overline{\text{N}}}\) UNCERTAIN \(\Boxed{1}\) has b Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate to the State **EXAMINER?** HOSPITAL: 1 YES 2 X NO 1 | Inpatient 2 | ER/Outpetient 3 | DOA 4 Nursing Home 5 Rasidenca 6 X Other (Specify) GROUP HOME the 27. MANNER OF OEATH 28a. DATE OF INJURY 28b. TIME OF 26c. INJURY AT WORK? this c marked 1 Netural
2 Accident 5 Pending 1 YES 2 NO BY After I Investigation ATTENDING 3 Suicide 28s. PLACE OF INJURY — At home, farm, etreet, factory, office building, etc. (Specify) .00 6 Could not be DIRECTOR: hours after of COMPLETED 28 4 Homicide datermined Hem 8 29e. CERTIFIER
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) HOSPITAL FUNERAL I = TO THE HOSPITA
TO THE FUNERAL
DE filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29g. LICENSE NUMBER BE religion Wohere 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL ANCHORS, M.D., 16220 FREDERICK ROAD, SUITE #210 GAITHERSBURG, MD 20877 31. DATE FILEO (Month, Day, 16ar)
APR 14 1995 32. HEGISTHAR'S SICHATURE

WEISS

6. AGE (In yrs. last birthday)

CERTIFICATE OF DEATH

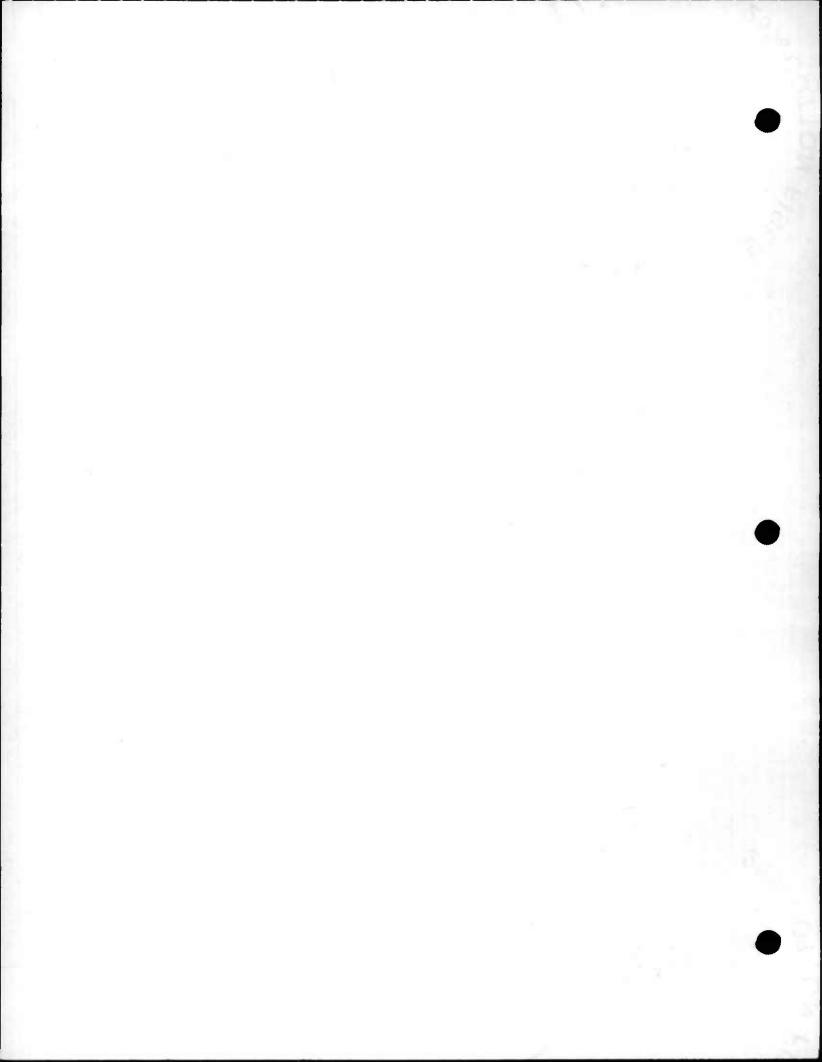
IF UNDER 1 YEAR

IF UNDER 24 HRS.

95 13026 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO. 2. DATE OF DEATH DAY 3. TIME OF GEATH APRIL 11, 1995 2:10 P. M 7. DATE OF BIRTH 6. BIRTHPLACE (State or Formign OCT. 15, 1902 HUNGARY 9c. COUNTY OF DEATH MONTGOMERY 10d. INSIDE CITY YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? UNITED STATES 14. RACE — American Indian, Black, White, etc. WHITE 16b. KIND OF BUSINESS/INDUSTRY OWN HOME "UNKNOWN" 20c. LOCATION — City or Town, State ALEXANDRIA, VIRGINIA DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 Interval Batween **Onset and Death** Z WEEKS 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 XNO 1 TYES 2 NO 28d, OESCRIBE HOW INJURY OCCURED 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

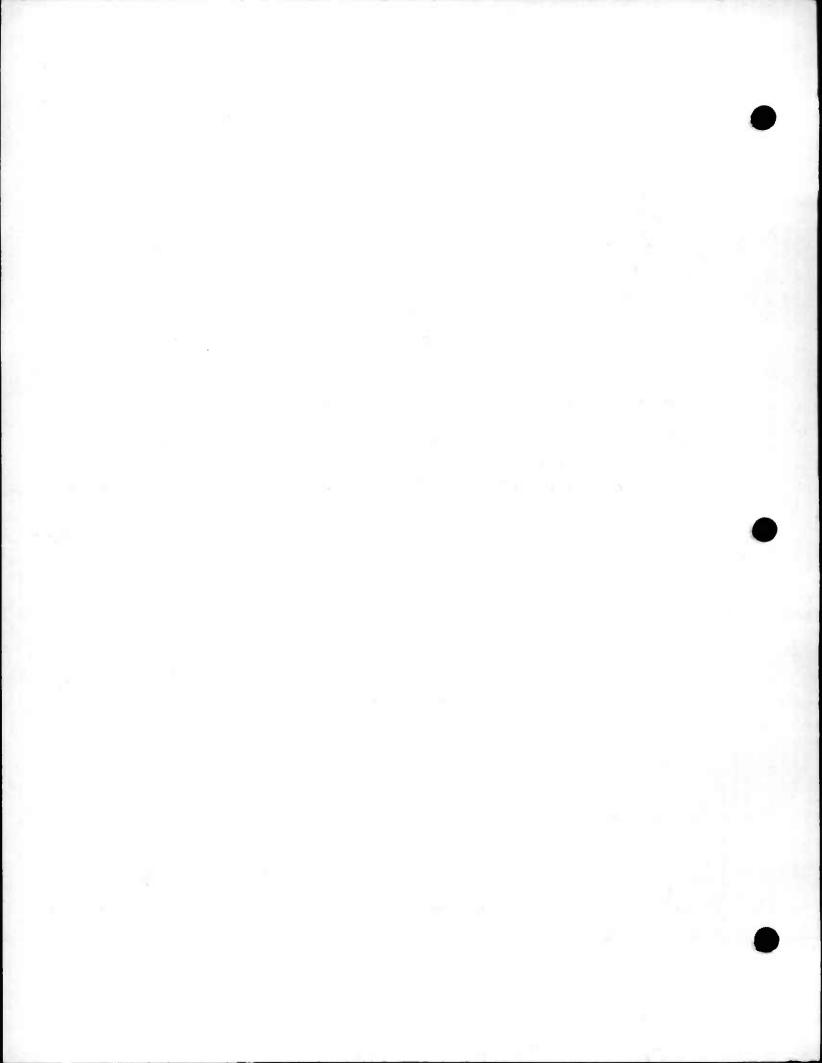
29d, DATE SIGNED (Month, Day, Year)

APRIL 11, 1995



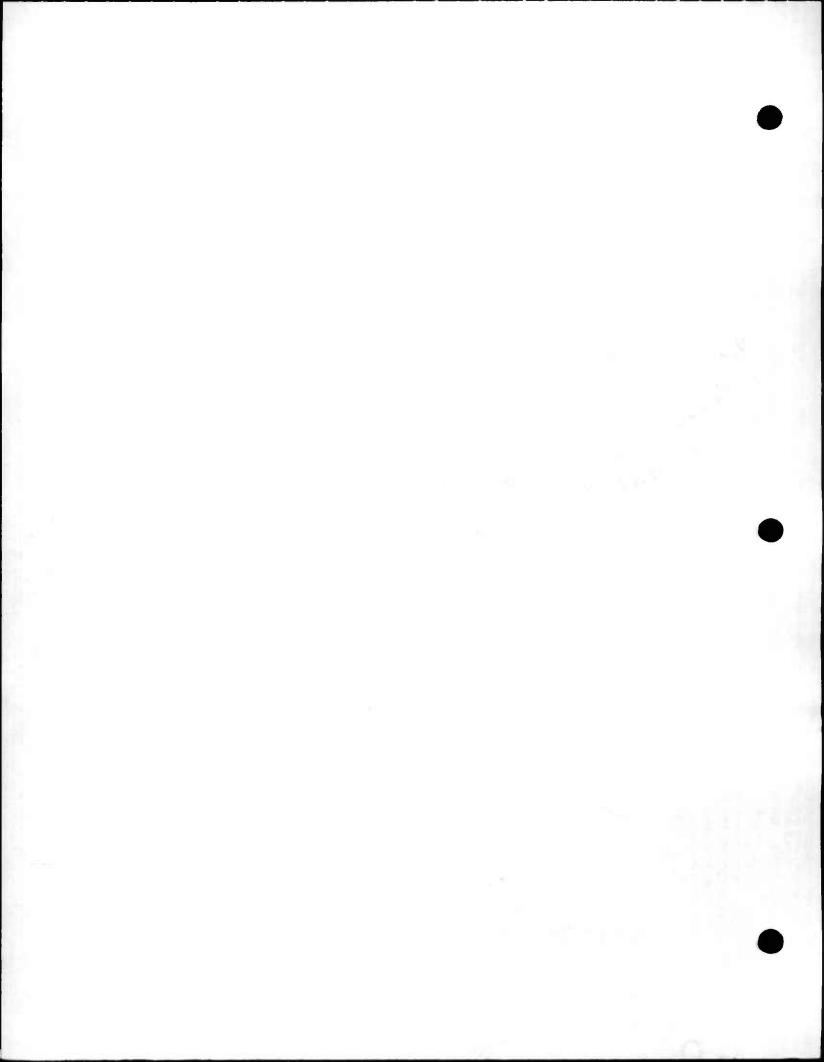
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / CE	DEPARTME				GIENE G. NO.	13021		
1	1. OECEDENT'S NAME (First, Middle, Last)				2. DATE OF DE	ATH	3. TIME OF DEATH		
- 9	John R. Wilson, Jr.				April	11, 1995	5:50 A M		
	4. SOCIAL SECURITY NUMBER 219-01-3692 5. SEX 6. AGE (In yrs. less 77	YRS. F UNI	DER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIF (Month, Day, June 2	TTH 8.	BIRTHPLACE (State or Foreign Country) Maryland		
. 7	9e. FACILITY NAME (If not institution, give street and number)			R LOCATION OF DE		9c. COUNTY	OF DEATH		
OR	Wilson Health Care Center	G	aither	rsburg		Montg	gomery		
딦	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	10c, CITY, TOW	N OR LOCATI	ON			tod, INSIDE CITY		
. DIRECTOR	Maryland Montgomery	10		umascus XX					
FUNERAL	100. STREET AND NUMBER 26820 Ridge Road		101.	109. CITIZEN OF WHAT COUNTRY? United States					
BY FUN	11. MARITAL STATUS 1 Never Merried 2 X Merried 3 Widowed 4 Divorced 12. WAS OCCEDENT EVER IN U.S. AR FORCES? 1 YES 2 Y WA IF YES, GIVE WAR OR OATES	If yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, Wh				Black, White, etc. Specify: White			
ED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) (G	CEDENT'S USUAL	OCCUPATION	N	16b. KIND	OF BUSINESS/INOUS	TRY		
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)	ive kind of work doi . Do NOT use retired nister	ne during mos d.)	t of working	Re	ligion			
WO	17. FATHER'S NAME (First, Middle, Last)	1110001		18. MOTHER'S NA					
BE C	John R. Wilson, Sr.					h Miener			
TO B		208 7 2							
	Virginia L. Wilson 26820 Ridge Road, Damascus, Maryland 20872 20e. METHOO OF DISPOSITION 15/1 Burlel 2 Cremetion 3 Remove from State 4 Donetion 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, gremetory or other place) Parkwood Cemetery 4/14/95 Baltimore, Maryland								
	4 Donation 6 Other (Specify) Parks					<u>Baltimore</u>	, Maryland		
	Muril H-Barber	/ [Muriel		ber Fun	eral Home	20882 Maryland		
	23. PART I. Enter the diseases, or complications that caused the de	ath. Do not ent	ter the mod	le of dying, suc	h as cardiac o	r reapiratory arrest	t, Approximate interval Between		
	ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition reaulting in death) a. Cerebra + hrom + bos1s OUE TO (OR AS A CONSEQUENCE OF):								
z	Combal actoriosclansis								
CATIO	cause. Enter UNDERLYING								
CERTIFICATION	CAUSE (Disease or injury that initiated eventa reaulting in death) LAST	DUENCE OF):							
	PART II. Other significant conditions contributing to death but not n	neulting in the	underhilee	annia aluan la	Don't las i	MAS AN AUTOPSY			
MEDICAL		ecuting in the	underlying	cause given in	- 1	PERFORMEO?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?		
. ME	DID TODACCO LICE CONTRIBUTE TO CALL	CE OF DE	- A TIL W	FC [7] N/			t 🗆 YES 2 XNO		
IAN	DID TOBACCO USE CONTRIBUTE TO CAU 25. WAS CASE REFERRED TO MEDICAL	SE OF DE		CE OF DEATH (Ch					
Sic	EXAMINER? 1 YES 2 RO HOSPITAL: 1 Inpetient 2 ER/Outpetient 3	DOA OTH	ER:	5 🗆 Residenca		fb)			
Y PHYSICIAN:	27. MANNER OF DEATH 1 Netural 5 Pending 28e. OATE OF INJURY (Month. Day, Year)	28b. TIME OF INJURY	28c. INJU WOF	RY AT		HOW INJURY OCCUR	RED		
red BY	2 Accident Investigation 3 Suicide 8 Could not be determined 28a. PLACE OF INJURY — At hos building, etc. (Specify)	me, ferm, street, f			281, LOCATION City or Town	(Street and Number or in, State)	Rural Route Number,		
COMPLET	29e. CERTIFIER (Check only one) CERTIFVING PHYSICIAN: To the best of my knowledge, de-								
	2 MEDICAL EXAMINER: On the beals of exemination and/or I	investigation, in m	ry opinion, de	ath occured at the 29c. LICENSE NUM			euse(a) and manner as stated.		
TO BE	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITE)	H 27) (Form Print)	0	072	31	► Apr	-111,1995		
			Ave	Gais	therot	uca mi	20877		
	APR 12 1995 Juli Savelus Randell)			



DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND	DEPAR ERTIFI	MENT OF I	IEALTH AND DEATH	MENTAL HYGIENI	E		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATN	
	Ruth	Warner				April 11,	1995 YEAR	7:25 A M	
		5. SEX 6. AGE (In yrs. Is		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTH Count	IPLACE (State or Foreign	
	227 3 . 7 .20	1 □ M 2 🗓 F 85	YRS.			Nov 8, 190	09 Mai	ryland	
Œ	9e. FACILITY NAME (If not institution, give street				OR LOCATION OF O	EATH	9c, COUNTY OF D		
01,	Frederick Memoria	II HOSPITAL		Fred	erick		Frede	erick	
DIRECTOR	10e. STATE 10b. COUNTY		10c, CITY, TOWN OR LOCATION					10d. INSIDE CITY	
ā		lerick	Frederick					LIMITS? 1 YES 2 X NO	
RAL	100. STREET AND NUMBER 5741 Elmer Derr R) J	101. ZIP CODE				WHAT COUNTRY?		
FUNERAL		OACI 12. WAS DECEDENT EVER IN U.S. AI			2170	_	U.S.		
	1 Never Married 2 Married	FORCES? 1 YES 2 X	ES? 1 YES 2 XNO			NIC ORIGIN? (Specify Yea in, Puarto Rican, etc.)	Black	E — American Indian, k, Whita, atc.	
B	3 🔀 Widowed 4 🗌 Divorced	IF TES, GIVE WAR ON DATES	1 U YES	2 NO Specif	y:	Spec	"White		
COMPLETED	15. DECEOENT'S EDUCAT (Specify only highest grade co	mpleted) (C	Sive kind of w	SUAL OCCUPATION done during me	ON st of working	16b. KIND OF BUS			
E.	Elementary/Secondary (0-12)	College (1-4 or 5+)	Food Preparation						
M	17. FATNER'S NAME (First, Middle, Last)		Food	Prepara			Care Cer	nter	
	William Evers	SHOOK			EVVIC	ME (First, Middle, Maiden S		4ETDM A NT	
BE	-1.020 01.0010			ADDRESS (Street a		Route Number, City or Town		TERMAN	
유	Mr. Hugh Warner					d, Frederic		and 21701	
	20e. METNOD OF DISPOSITION 1X Burlel 2 ☐ Cremetion 3 ☐ Remove		ANDDATEO	F DISPOSITION (Na		OATE 20c. LOC			
	4 Donation 5 Other (Specify)	St. L	ematory or oth uke's	Cemete	v Apr	13,1995 Fre	derick.	Maryland	
	21. SIGNATURE OF FUNERAL SERVICE LICEN	10		VOOME AN	D ADDRESS OF FA	CILITY	TT		
- 1	Keth hypan	Kobesen:	M0070	6 106 E	st Chur	ch St. Fred	. nome	m 21701	
	23. PART I. Enter the diseases, or cor	mplications that caused the de at only one cause on each line	eaul. Do No	ot anter the mo	de of dylng, suc	h as cardiac or reapir	atory arrest,	Approximata	
	IMMEDIATE CAUSE (Final	n only one cause on each line	B.					Interval Between Onset and Death	
	disease or condition	DUE TO (OF AS A CONSE	un	1 west					
	A								
ON	Sequentially list conditions, b.	OUE TO (OR AS A CONSE	EQUENCE OF:					yen1	
CERTIFICATION	If any, leading to immediata cause. Enter UNDERLYING		,		,	•		1	
Ĕ	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONSE	OUENCE OF)	:					
E	resulting In death) LAST								
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS								
CAL		ecotic lyes			م ، د	PERFORM	MEO?	AMILABLE PRIOR TO COMPLETION OF CAUSE	
MEDIC						1 TYES 2	NO	OF DEATN?	
ä	DID TOBACCO USE CONTRIE	BUTE TO CAUSE OF DEA	TH YES	NO D	UNCERTAIN	<u>ч</u> п	1	1 YES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		CE OF OEATH	(Check only one)					
YSI	1 YES 2 160 y	Inpatient 2 ER/Outpatient 3		OTHER: I Nursing Hom	5 - Residence	6 ☐ Other (Specify)			
	27. MANNER OF OEATN 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME INJU		JRY AT RK?	28d. DESCRIBE HOW IN	JURY OCCURED		
B	2 Accident Investigation	20-01-05-05-01-01-01		M 1 🗆 Y					
	3 Suicide 8 Could not be 4 Nomicide determined	28s. PLACE OF INJURY — At he building, atc. (Specify)	me, ferm, st	eet, factory, office		281. LOCATION (Street an City or Town, State)	d Number or Rural R	loute Number,	
COMPLETED	29a. CERTIFIER		(-)	17. 27.					
MP	(Check only CERTIFYING PHYSICIA	N: To the best of my knowledge, de							
8	Maya.	- 4/1 -	12	> un	29c. LICENSE NUN		29d. DATE SIGNED	1-1	
유	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETEO CAUSE OF DEATH (ITE	M 279-(Type-1	')	D16428)		12/91	
ł	Casper E. Cline, I	II, M.D., 300 V	West N	Winth St	reet. Fr	rederick M	arvland	21701	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAMS SIGNATURE	2016			Tack Tolk, II	or Jamid	21/01	
	APR 1 2 1995	James to the second	money!						



3. TIME OF DEATH

6. BIRTHPLACE (State or Foreign Virginia

> 10d. INSIDE CITY 1 YES 2 NO

> > White

10g. CITIZEN OF WHAT COUNTRY? United States 14. RACE — American Indian, Black, White, etc.

Ellicott City21043

Approximata interval Batween **Onsat and Death**

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 YES 2 NO

2, DATE OF DEATH

FOR STATE REGISTRAR

31. DATE FILED (Month, Day, Year)

1995

1. DECEDENT'S NAME (First, Midple, Last)

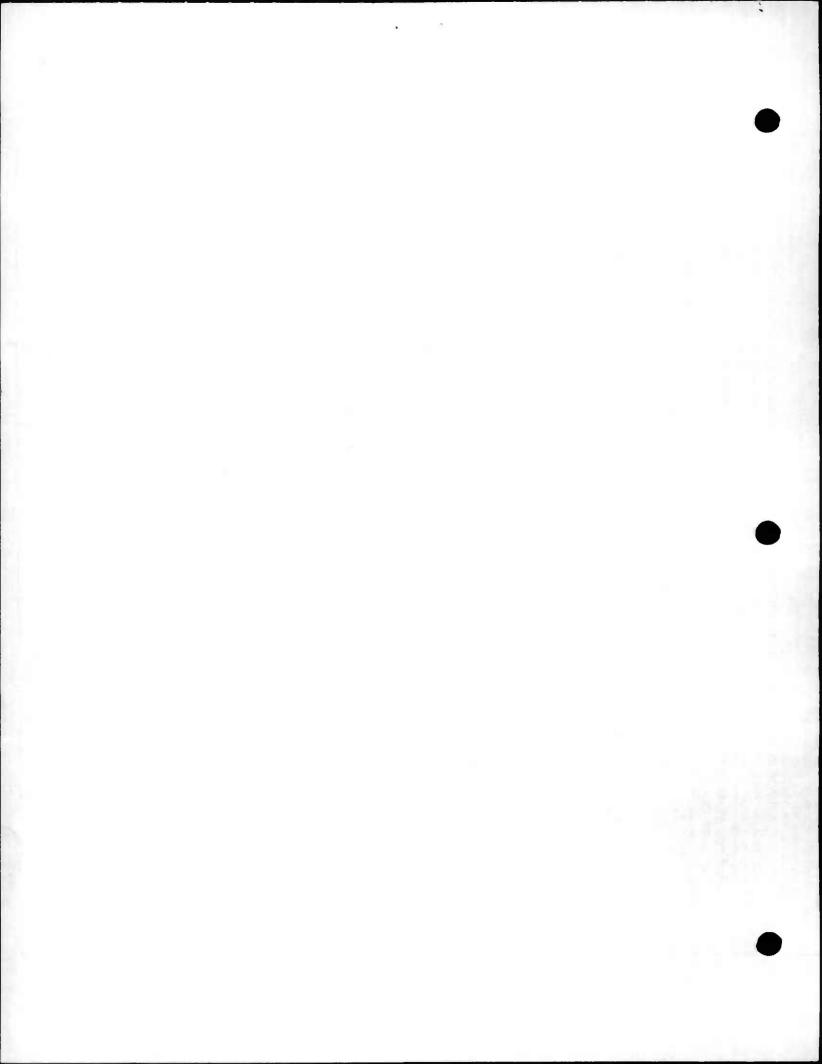
DIVISION OF VITAL RECORDS, P.O. BOX 68760

		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yr	rs. last birthday)	IF UNDER 1 Y	_	IF UNDER 24 HR	s. 7. DATE	OF BIRTH			LACE (State
-		224-01-1381	1 🔀 M 2 🗆 F	79	YRS.	MONTHS	MY8	HOURS MIN	Oct	5, 19	15	Vir	ginia
should	1 8	Sa. FACILITY NAME (If not institution, give	street and number)			9b. CITY, TO	OWN C	OR LOCATION OF			9c. COUN	_	
(C)	DIRECTOR	St. Agnes Hospit			Ba	alt	imore				Balt	imore	
physician. burial-transit permit. Pages 1, 2,	<u>5</u>	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION											
Page	<u>E</u>	Contraction of the contraction o									10d. INSIDE LIMITS?		
Ĕ		Maryland Balt	imore		l B	altimo	_						1 YES 2
# be	A I	1,11,131,131,131,3133,313						ZIP CODE					HAT COUNTR
ian. trans	FUNERAL	927 Circle Drive						21227				ted	State
physician burial-tra		1 Never Married 2 Married	12. WAS DECEDENT FORCES? 1	YES 2	- ™ NO	13. WA	S DEC	ENDENT OF HIS	PANIC ORIGI	N? (Specify Yea Rican, etc.)	or No-		- American White, atc.
	B	3 Widowed 4 Divorced	IF YES, GIVE WA	R OR DATES	3	1 [YES	2 № NO Sp	ecify:			Specify	Whit
attending se as the	8	15. DECEDENT'S EDU	CATION	16:	. DECEDENT'S	USUAL OCCU	JPATIO	ON	161	. KIND OF BUS	SINESS/INDI	ISTRY	VVIIIC
5 7		(Specify only highest gradi Elementary/Secondary (0-12)	College (1-4 or 5+)		(Give kind of a life. Do NOT us	vork done duri	ng mo	st of working	"		JIIVE 33/11VD	31111	
g gi	COMPLET	5			Dock Hand					Ship	Repai	r	
he hospit detached once.	0 0	17. FATHER'S NAME (First, Middle, Last)			-			18. MOTHER'S	NAME (First.	Middle, Maiden	-		
इ द्व		John R. Ware			Annie Lee Hal								
5 should notified	B	19a, INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS (S	treet a	nd Number or Ru	ral Route Num	ber City or Yow	n State Zin (Codel	
	임	Velda Ware						eet and Number or Rural Route Number, City or Town, State, Zip Code) Drive Baltimore, MD 21227					
may be X, page		20s. METHOD OF DISPOSITION		20b. PL/	ACE AND DATE				DAT	-	CATION — C		n State
9 5 3		1 ☐ Buriet 2 🔀 Cremation 3 ☐ Rent 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	cemeter	v. crametory or of	thar place!		remator			urel,		177111
		21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	Du	C Masi	22, NA	ME AN	D ADDRESS OF	FACILITY				
death. Pag funeral di I. examiner		D 11	-					H. Wit					
2 2 7		23. PART I. Entar tha diseases or		NA		411	2	01d Co1	Lumbia	Pike	Ellic	ott	City2
within hour pletely filled is cremation, or rent, the min		shock, or heart safere. Liet only one ceuse on each line. iMMEDIATE CAUSE (Fine) disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF):											
be exect cian and for to bur	CATION	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING							-				
certificat ding phy tygiene p	ERTIFIC	CAUSE (Disease or Injury that initiated events resulting in death) LAST	OR AS A COI	A CONSEQUENCE OF):									
death e atten ental h	핑		d										-
that the led by the th and M any infe	MEDICAL	PART II. Other significant condition	s contributing to d	eath but n	ot resulting i	n tha unde	riying	cause given	in Part I.	24s. WAS AN PERFOR 1 YES 2	MED?		VERE AUTOPS WAILABLE PR COMPLETION OF DEATH?
of of		DID TOBACCO USE CONT	DIRLITE TO CALL	SE OF P	EATU VE	c \square No		LINICEDE	NAL 🖂				YE\$ 2
Se es es	AN	25. WAS CASE REFERRED TO MEDICAL	KIBUTE TO CAU		PLACE OF DEAT			UNCERTA	AIN L				
tate ate	S		HOSPITAL:			OTHER:							
SICIAN: certifica h the Sta	PHYSI	27. MANNER OF DEATH	1 npatient 2 1		26b. TIM	7		5 Residence					
PHY this	BY P	1 Natural 5 Pending 2 Accident Investigation	Worth, Day	Year)	INJ	M 1	WOF	ES 2 NO	26d. DE:	SCRIBE HOW IN	JURY OCCU	RED	
OR ATTENDING DIRECTOR: After hours after death	ETED	3 Suicide 6 Could not be 4 Homicide determined	26a. PLACE OF building, at	c. (Specify)	- ST A			_	28f. LOC City	ATION (Street a or Town, State)	nd Number o	r Rural Ro	ute Number,
4 4 2 =	COMPLE		CIAN: To the best of m										and menner a
물 물 물	8	296. SHEALTH AND TITLE OF CERTIFIE		1	W.	9	7	29c LICENSE N		P9		/	Month, Day, Ye
6 6 % X	2	30. NAME AND ADDRESS OF PERSON WH	TAL G			-		Th 301	543		06/	15	1/3
	- 4	77110111	,	- ,)	1 "	- 3	34	49 W	KUKEN	5 A19	17	14	

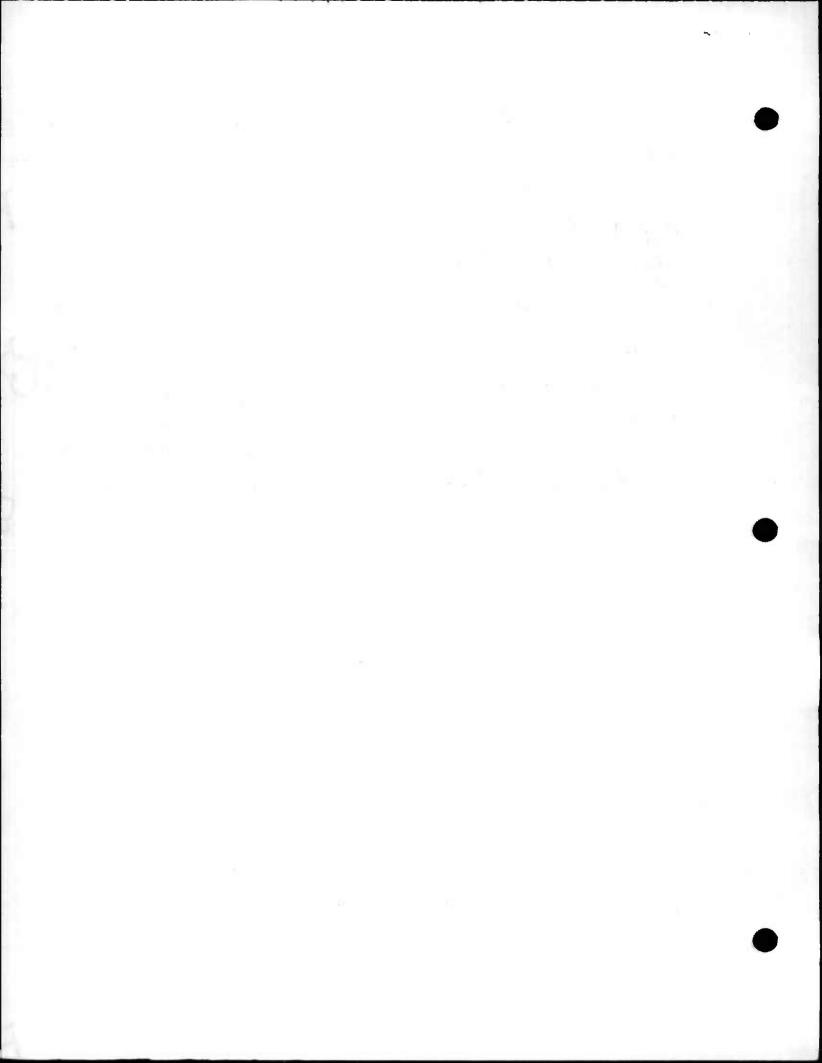
32 AEGISTHAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

DHMH-16 Rev 1/89



	_	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.								
		1. DECEOENT'S NAME (First, Middle, Lost) 1. DECEOENT'S NAME (First, Middle, Lost) 1. DAVID M. WALLS 2. DATE OF DEATH MONTH PRIC 9, 1995 6.14 P) M							
Pin		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) If UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Veer) WAS hington Output Days 1 IM 2 IF 1 IM 2 IF 1 IF UNDER 1 YEAR 1 INDER 1 HOURS MINH. DAYS HOURS MINH. DAYS HOURS MINH. DAYS 1 INDER 14 HRS. 1 DAYS DAYS OUTPUT DAYS OUTP	C							
I, 2. 3 should	TOR	90. FACILITY NAME (If not institution, give street and number) 90. COUNTY OF DEATH 90. COUNTY OF DEATH PAINCE BROWNER RESIDENCE OF DECEDENT	2							
permit. Pages 1	DIRECTOR	100. STATE 100. COUNTY 100. CITY, TOWN OR LOCATION 100. INSIDE CITY LIGHTS? 1 Prince George Clinton 100. No. COUNTY 1 Pres 2 \(\text{No.} \)								
usit	ERAL	7517 Surratts Road 20735 USA								
215-0020 attending physician. Ise as the burial-transit	BY FUN	11. MARITAL STATUS 12. WAS DECEDENT EVEN IN U.S. ARMED FORCES? 1 VES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or NO— Black, White, etc.) 14. RACE — American Indian, Black, White, etc. 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NO— Black, White, etc.) 16. RACE — American Indian, Black, White, etc. 17. YES, GIVE WAR OR DATES 18. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NO— Black, White, etc.) 19. Was DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NO— Black, White, etc.) 19. Was DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NO— Black, White, etc.)								
21 al or for u	PLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4 or 5 +) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY								
YLAND 2 by the hospital be detached to at once.		17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)								
MAR retained 5 should notified	TO BE	196. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	_							
FORE, I e 6 may be ector, page 6		CO. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION / DATE 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State								
BALTIMORE, ter death. Page 6 may be the funeral director, page wat.		Donotion 5 Other (Specify) NIT Veterans Cen 4/13/95 Chelfenhan MI) 1. SIGNATURE OF PUNEHAL BERVIOLE DCENSEE 22. NAME AND ADDRESS OF FACILITY	_							
E 3 % a		23. PART I. Enter the dispasses, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate								
hin 24 hour tely filled in mation, or t, the me		Interval Between Onset and Death disease or condition a. Respiratory faulture 3 days 3 days								
N 2 2 = 0		Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):								
BO ficate be physicial ne prior	ERTIFICATION	CAUSE (Disesse or injury that initiated events Due to (or as a consequence of):								
U + 5 5 5	1 25 1	dd.								
and and		PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 248. WAS AN AUTOPSY PERFORMED? 1 YES 2 PNO 249. WERE AUTOPSY FINDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	S							
OF VITAL RECOI HYSICIAN: The law requires the tinis certificate has been signed with the State Dept. of Health of ked, or Item 23 shows am		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN								
VITAL I AN: The law tificate has by e State Dept. or Item 23 or	SICI	28. PLACE OF DEATH (Check only one) EXAMINER? 1 YES 2 NO 28. PLACE OF DEATH (Check only one) OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)								
		27. MANNER OF DEATH 1 Neturel 5 Pending Investigation Investigation Pending								
TTENDI TOR: A after de		3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, ferm, street, fectory, office City or Yown, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Yown, State)								
DIV HOSPITAL OR A FUNERAL DIREC WITHIN 72 HOURS STANT: If item	COMPLET	Se. CERTIFIER (Check only one) 1. CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner es stated. 2. MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner es stated.								
TO THE HOSPITAL TO THE FUNERAL De filed within 72 h	出	96. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 410455	_							
	10	O. NAME AND ADBRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VARKEY-MATHEW MD. SWITEIA, 3710 RIVIERA ST. MD. 20748								
		APR 1 8 1995	_							



death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Deot. of Health and Mental Moleine prior to burial cremation, or removal	examiner must be notified at once.
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the ibe fled within 72 hours after death with the State Dept. of Health and Mental Hydiele prior to busial cremanion or removal	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

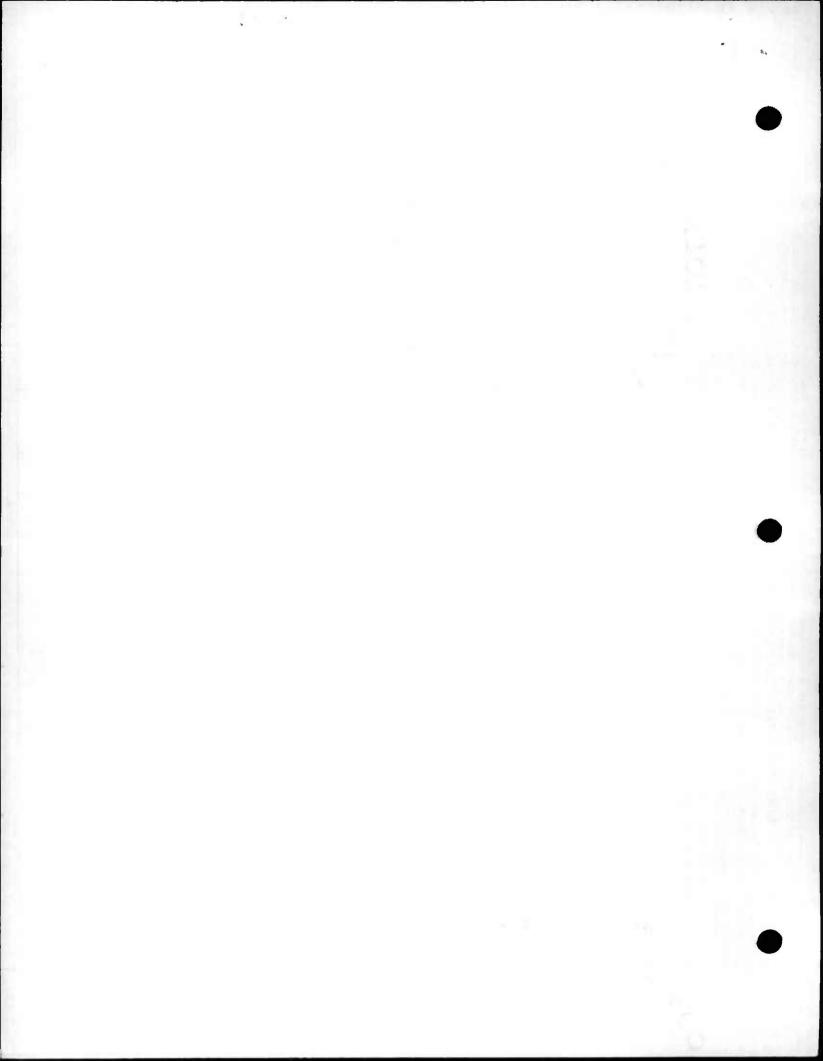
PICHARD J 31. DATE FILED (Morth, Day, Year) APR 1 7 1995

COLFER, MD.

32. REGISTRAR'S SIGNATURE

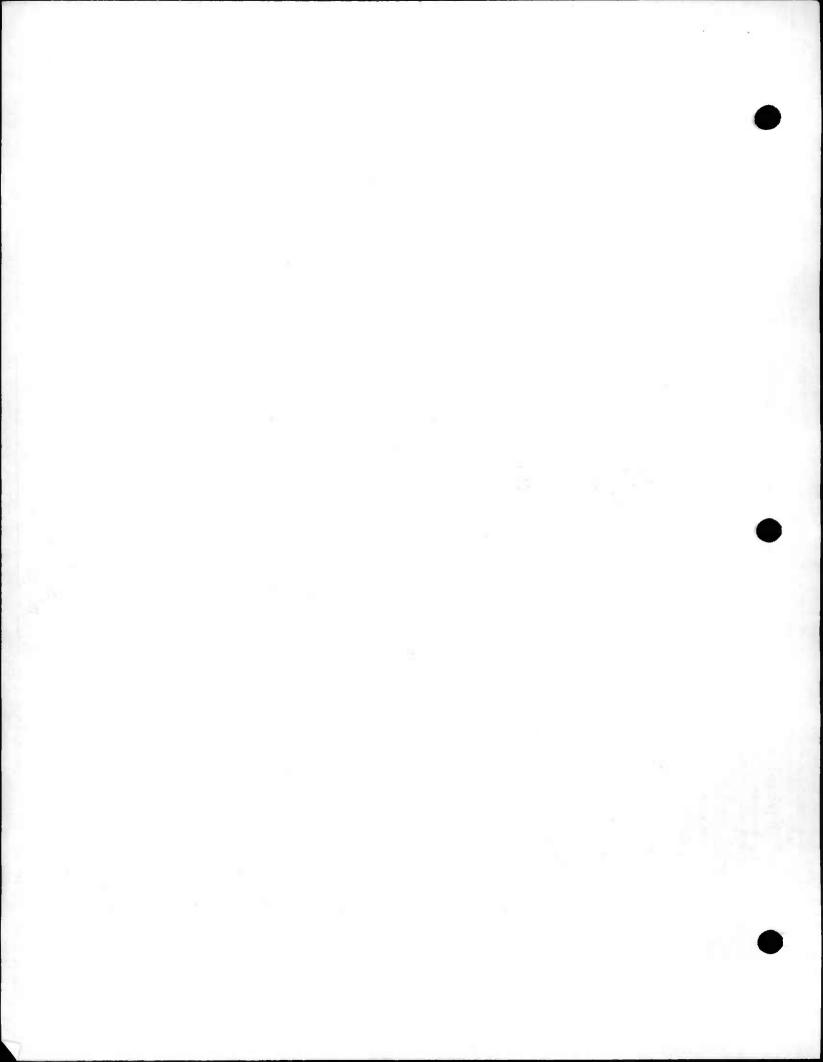
FAUL DANNESS RANGEL

							9	5 1	3031	
	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ID / DEPAR CERTIF	TMENT OF H	EALTH AND M	IENTAL HYGIEI				
	1. DECEDENT'S NAME (First, Middle, Last) THOMAS H	DUARD	WILL,	IAMS		2. DATE OF DEATH MONTH	MONTH DAY YEAR			
	4. SOCIAL SECURITY NUMBER 240–20–0246		rs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH 8. BIRTHP (Month, Day, Year) Country			ACE (State or Foreign	
R	9e. FACILITY NAME (If not institution, give etc.			OR LOCATION OF DEA	THUY. JIT	TH 9c. COUNTY OF DEATH				
בל	410 Dawn Court RESIDENCE OF DECEDENT 100. STATE 100. COUNTY		100 CITI	Aberdeen 10c. CITY, TOWN OR LOCATION				Harfrod		
L DIRECTOR	Maryland 10. STREET AND NUMBER	Harford		perdeen			10d.			
FUNERAL	410 Dawn Court		101. ZIP CODE 21 001			10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
BY	11. MARITAL STATUS 1			ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN If yes, specify Cuben, Mexican, Puerto 1 YES 2 SNO Specify:			PRIGIN? (Specify Yes or No			
COMPLETED	(Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4 or 5+)			DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of workling life. Do NOT use retired.)			JSINESS/INI			
M C	7 0 I			nic			tomob	ile		
BE C	17. FATHER'S NAME (First, Middle, Melden Surneme) James Edward Williams Mary Elizabeth Stanford									
TO B	196. INFORMANT'S NAME (Type/Print) 196. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
F	Mrs. Belva J. Williams 410 Dawn Court, Aberdeen, Maryland 21001									
	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remove 4 Donation a Other (Specify)	val from Stata cameter	ry cremetory or ot	her piece)		0ATE 20c. L		City or Town,		
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE		22. NAME AN	D ADDRESS OF FACI	LITY	- 11			
	Busten A	ny Ung	lush	Abe	rıng-Carg rdeen, Ma	o Funera ryland	L Hom 21001	е, Р. <i>Р</i> -3399	A.	
	IMMEDIATE CAUSE (Final	int only one cause on aach	i line.	ot entar tha mo	da of dying, such	as cardiec or reap	olratory an	reat,	Approximeta Interval Batwean Onset and Death	
NO	disease or condition resulting in death) a. CARCINOMA OF PROSTATE WITH DUE TO (OR AS A CONSEQUENCE OF): METASTASE S b. DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury c.									
ERTIF	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST d.									
PHYSICIAN: MEDICAL (PART II. Other aignificant conditions	contributing to death but i	not reaulting in	n the underlying	ceuse given in P	ert I. 24s. WAS AF PERFO	RMED?	AM CO	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH!	
Σ	DID TOBACCO USE CONTRI	RUTE TO CAUSE OF I	DEATH VE	S D NO D	UNCERTAIN		, •	1 (YES 2 THO	
MAN	25. WAS CASE REFERRED TO MEDICAL	26.		H (Check only one)	UNCERIAIN					
YSIC	1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpatie	nt 3 🗆 DOA	OTHER: 4 - Nursing Home	5 Rasidence 8	Other (Specify)				
ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. INJURY WOL	RK?	28d, DESCRIBE HOW	INJURY OC	CUREO		
						City or Town, State	end Number)	or Rural Route	e Number,	
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(e) and menner as stated.									
TO BE	296. SIGNATURE AND TITLE OF CERTIFIER RELIGION OF CO									
•	30. NAME AND ADDRESS OF PERSON WHO	OLFER, MD	(ITEM 27) (Type,	Print) 2013 DAR	ING TO	N, MARY	HAND	210	34	



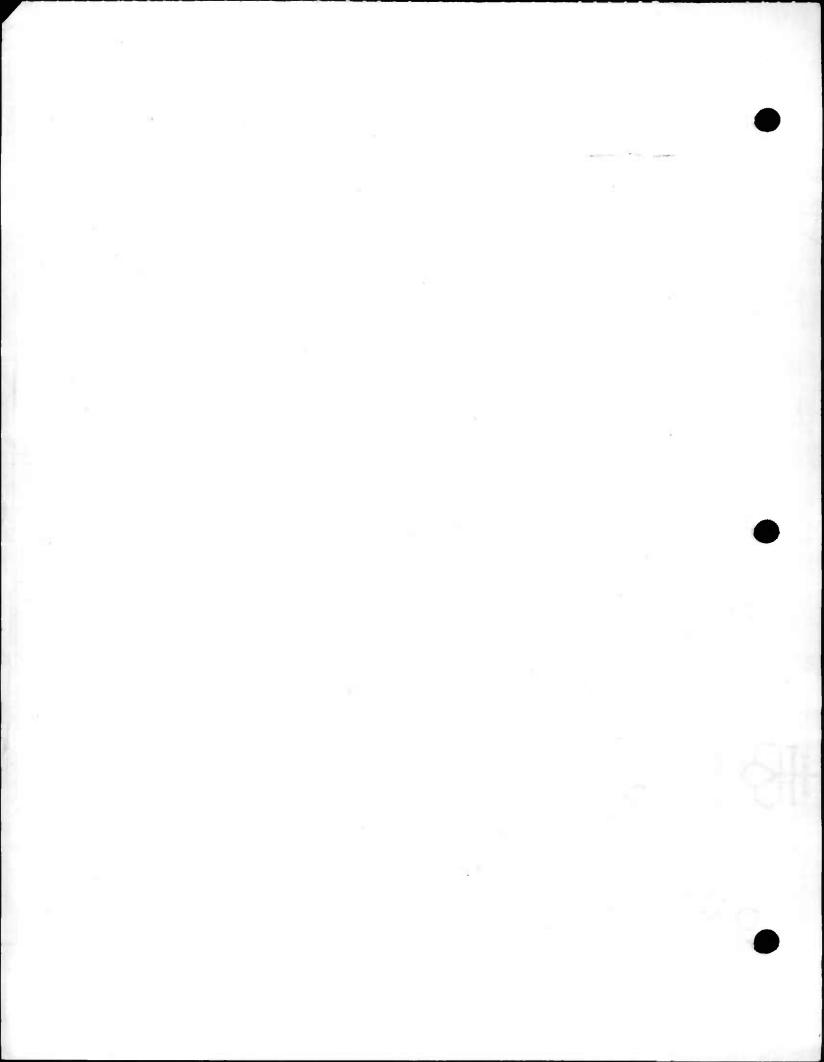
į	eath.	funera		
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funera	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
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	1 - FOR STATE REGISTRAR	STATE OF MARYLAND /	DEPARTMENT OF ERTIFICATE O		MENTAL HYGIENI REG. NO.	E				
	1. OECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DA	Y YEAR	3. TIME OF DEATH			
	LOUIS	GRANI		UNG Jr.	APRIL 11		8:43 P M			
		SEX 6. AGE (In yrs. las	MONTHS DAY		7. DATE OF BIRTH (Month, Day, Year)	8. BIRTH Count	HPLACE (State or Foreign			
		x-x ^{M 2 □ F} 70	YRS.		Oct. 22,	1924 Ma				
000	9a. FACILITY NAME (If not institution, give street DUVCTCTANC MEMO			OR LOCATION OF DE	EATH	9c. COUNTY OF D				
1 5	PHYSICIANS MEMORIAL HOSPITAL LA PLATA CHARLES									
DIRECTOR	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY									
	Maryland Char	les	Waldor	£			LIMITS?			
\ ₹	10e. STREET AND NUMBER			101. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?			
FUNERAL	1107 Falmouth D			20601		U.S.	A			
5	11. MARITAL STATUS 12 1 Never Married 2 Merried	2. WAS DECEDENT EVER IN U.S. ARI FORCES? 1 YES 2 N		ECENOENT OF HISPAI apocify Cuban, Mexica	NIC ORIGIN? (Specify Yes	or No- 14. RACI	E — American Indian, k, White, etc.			
₽	2 Midamed A D Division of	1943-1945	יםי	ES 2 NO Specif	y:	Spec	Black			
0	15. DECEDENT'S EDUCAT	ION 16s, DE	CEDENT'S USUAL OCCUPA	TION	16b. KIND OF BUS	INESS/INDUSTRY	БІАСК			
ᇦ	(Specify only highest grade con Elementary/Secondary (0-12)		ive kind of work done during Do NOT use retired.)	most of working						
필	12		Clerk		U.S.Go	overnme	n t			
once. COMPLET	17. FATHER'S NAME (First, Middle, Lest)			18. MOTHER'S NA	ME (First, Middle, Maiden S					
examiner must be notified at once. TO BE COM	Louis Grant You			Genevi	eve	Toy	е			
2	19e. INFORMANT'S NAME (Type/Print)	j.	b. MAILING ADDRESS (Street							
9	Frances C. Wash:				Waldorf N					
<u> </u>	1-Burial 2 Cremetion 3 Removal	t from State cametery, cres	AND DATE OF DISPOSITION matory or other place)			CATION — City or To	20			
	4 Donation 5 Other (Specify)	SEE MD V		AND ADDRESS OF FA	14/95 Che	<u>eltenha</u>	m MD			
Ē	7100	0	22. NAME	AND ADDRESS OF FA	CILITY					
	Lloyd to	tes	Adam	Funera	1 Home, Ac	luasco	MD 20608			
medical	21. PART I. Enter the diseases, or com shock, or heart failure. List	nplications that caused the de- t only one ceuse on each line.	eth. Do not enter the	node of dying, suc	h as cardisc or reapir	ratory errest,	Approximats Interval Between			
	IMMEDIATE CAUSE (Final disease or condition	DI.	1 0				Onsat and Dasth			
H,	resulting in death)									
2	DUE TO (OR AS A CONSEQUENCE OF):									
	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury) Level words curlent Accident 4 days CAUSE (Disease or injury)									
A E	csuse. Enter UNDERLYING Cleve broves curlen Secretary 4 ola. C									
IFI I	CAUSE (Disesse or injury that initisted events	DUE TO (OR AS A CONSEC	DUENCE OF):				1 3244			
CERTIFICATION	resulting in death) LAST									
	PART II. Other significent conditions c	ontributing to death but not n	esulting in the underly	na ceues alves in	Bart I Jan Man And	AUTODOY OU	WERE AUTOPSY FINDINGS			
			outing in the uncerty	ing couse given in	PERFORI	MED2	AMILABLE PRIOR TO COMPLETION OF CAUSE			
snows any					1 D YES 2	() NO	OF DEATH?			
2 2	DID TOBACCO USE CONTRIB	LITE TO CALISE OF DEA	TH VES I NO	☐ UNCERTAIN			1 YES 2 NO			
ted, or item 23 snows any PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL		E OF DEATH (Check only of		101					
SICI		OSPITAL: Inpatient 2 - ER/Outpatient 3	OTHER:	ome 5 🗆 Residenca	8 G Other (Specific)					
H Y	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME OF 28c.	NJURY AT	28d. OESCRIBE HOW IN	JURY OCCURED				
BY PH	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)		YES 2 40						
	3 Suicide 8 Could not be	26e, PLACE OF INJURY — At hor building, atc. (Specify)	me, farm, streat, fectory, of	lice	281. LOCATION (Street or City or Town, State)	nd Number or Rural F	Route Number,			
	4 Homicide determined				Oily or lown, State)					
P	29a. CERTIFIER 1 CERTIFYING PHYSICIAL	N: To the best of my knowledge, dea	ath occurred at the time, d	te end place, and due	to the cause(s) and ment	ner as stated.				
COMPLETED	one) 2 MEDICAL EXAMINERY	On the besis of examination and/or in	nvestigation, in my opinion	death occured at the	time, date end placa, end	due to the ceuse(s	s) end manner as stated.			
BE COMPLE	29b. SIGNATURE AND THE OF CENTY IER			29c LICENSE NUN	ABER	29d. DATE SIGNED	(Month Day, Year)			
TO B	10/			11)35	156	D 4/1	2/95			
F	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF OEATH (ITEM	1 27) (Type, Print) 109(5Ft.Was	hington R	load , Su:	it'e 405			
	Joseph Murbhy, M	1.D.	Ft.V	ashingt	on, Maryl	and 20	744			
	APR 1 8 1995	32. REGISTRAR'S SIGNATURE	_							
	APR 1 8 1995	The sound of the	mount							



BALLIMORE, MARYLAND	after death. Page 6 may be retained by the hospit	y the funeral director, page 5 should be detached noval.
	Sunou 42 Hi	ety filled in bration, or ren
DIVISION OF VILAL RECORDS, P.O. BOX 68/60	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospit	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.
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		1 - STATE REGISTRAR	STATE OF MARYL			HEALTH AND F DEATH	MENTAL HYGIEN REG. NO.	E	
	1	1. DECEDENT'S NAME (First, Middle, List) Phebe E. Zin	nmerman				2. DATE OF DEATH MONTH 12,	"1995 "	S. TIME OF DEATH 5:08 Pm
3 should		219-40-0922		(In yrs. last birthday) (In YRS.	IF UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year) January 1		BIRTHPLACE (State or Foreign
	_	9a. FACILITY NAME (If not institution, give street	et and number)			N OR LOCATION OF D		9c. COUNTY	OF DEATH
1, 2, 3	CTO	Homewood Retireme	ent Center		Fred	erick		Free	derick
physician. burial-transit permit. Pages 1, 2,	1 1	100. STATE 10b. COUNTY Maryland Frede	erick		v, town on Local alkersv:				10d. INSIDE CITY LIMITS?
permit.		10e. STREET AND NUMBER	- I I CK		I REISV.	101. ZIP CODE		10g. CITIZEN	1 YES 2 NO
transit		42 Maple Avenue	12 MAC DECEDENT EVED II	Alle ADMED	1 22 277 2 2	2179			ed States
		1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 DCNO	If yes,	Specify Cuben, Maxici ES 2 NO Specif		or No — 14.	RACE — American Indian, Black, White, atc. Specify: White
or attending r use as the		15. DECEDENT'S EDUCA (Specify only highest grade co	ompleted)	18e. DECEDENT'S (Give kind of life. Do NOT u	work done durina	TION most of working	16b. KIND OF BUS	SINESS/INDUST	TRY
the hospital o detached for once.		Elementary/Secondery (0-12)	College (1-4 or 5+) 4	Schoo	ol Teacl	ner	Edu	cation	
by the hose be detach		17. FATHER'S NAME (First, Middle, Last) Charles H. Routza	hn				ME (First, Middle, Malden	Sumame)	
e retained by the hospital 5 Should be detached to notified at once.		19e. INFORMANT'S NAME (Type/Print)	11111	19b. MAILING	ADDRESS (Street		e Cramer Route Number, City or Tow.	n, State, Zip Co	de)
y be rel	5	Kathryn Z. Nicode					Walkersvi		
e 6 mar rector, p		1 Buriel 2 Cremation 3 Ramov. 4 Donation 5 Other (Specify)	si from State 20b.	PLACE AND DATE Detery, crematory or of the OLIVe	of disposition; thar place) et Ceme:		1		or Town, State K, Maryland
death. Pag tuneral dii examiner		21. SIGNATURE OF FUNERAL SERVICE LICEN		0	22. NAME	AND ADDRESS OF FA	CILITYStauffe:	r Fune	ral Homes, P.A ick, MD 21702
		23. PAST I. Enter the diseases, or conshock, or heart failure. Li	mplications that caused st only one cause on e	the deeth. Do	not enter the r	node of dying, suc	h ee cardiec or reapi	ratDry arreat	Approximete interval Between
within 24 pletety fille cremation, rent, the		iMMEDIATE CAUSE (Finel disease or condition resulting in death)	DUE TO (OR AS A CONSEQUENCE OF): Oneet and Death 2h.g.						
executed and cor to burial,	RTIFICATION	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSEQUENCE OF):						
h certificat ending phy Hygiene p or other	CERTIFIC	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):						
200	CALC	PART II. Other significent conditions					Pert I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
w requires that been signed by pt. of Health an 3 shows any	MEDIC	(D) COPD	URE	(9) Der		1 - YES 2 1 NO		COMPLETION OF CAUSE OF DEATH?	
s been spt. of spt. of		DID TOBACCO USE CONTRI	BUTE TO CAUSE O	F DEATH YI	S NO	W UNCERTAIL	<u>, </u>		1 TYES 2 NO
cate has state De	PHYSICIAN		HOSPITAL:	26. PLACE OF DEA	OTHER:				
YSICIAN s certifi th the	ЭНХ	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIN	E OF 28c. I	NJURY AT YORK?	8 Other (Specify) 28d. DESCRIBE HOW II	NJURY OCCUR	ED
ING PH After thi leath wi marke	BY	1 Netural 5 Pending 2 Accident Investigation			M 1	YES 2 NO			
CTOR: /	TED	3 Suicida 8 Could not be 4 Homicide detarmined	28e. PLACE OF INJURY — At home, farm, street, fectory, office building, stc. (Specify)		rice	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires TO THE FUNERAL DIRECTOR: After this certificate has been signs be filed within 72 hours after death with the State Dept. of Healt IMPORTANT: If Item 28 is marked, or Item 23 shows a	COMPLE	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the pairs of exemination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(s) end manner as stated.							ouse(s) and menner es atated.
HE HO!	ш	296. SIGNATURE AND TITLE OF CARDITER	1 /			29c. LICENSE NUI	ABER	29d, DATE SI	GNED (Month, Day, Year)
5 5 5 W	10 B	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	ATH (ITEM 27) /Fina	Print)	D321	71	> 4	13/95
		RICHARD L. GO	GM, HOUC	_		CK ST. L	-ALKERSU	1 LLE 1	D 21793
		31. DATE FILED (Month, Day, Year) APR 1 7 1995	32. REGISTRAR'S SIGNA	LOS ROLL					



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REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Apr 27 1995 ABBOTT 3:25 am DAVID ALAN 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 33 1 X M 2 - F 212-78-5513 Nov Maryland Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OFATH DIRECTOR Baltimore Saint Joseph Medical Center Towson, Maryland RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore Maryland Towson 1 YES 2 X NO permit. FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 310 Stevenson Lane funeral director, page 5 should be detached for use as the burial-transit 21204 United States Page 6 may be retained by the hospital or attending physician. 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Noyes, specify Cuban, Mexican, Puarto Ricen, etc.) 1 Never Merried 2 Married 1 TYES 2 X NO A Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY tary/Secondary (0-12) College (1-4 or 5 +) 12 Sales Manager Food Store 4 17, FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Melden Surname) at Pedrick J. Abbot BE Shirlev A. notified a 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Shirley A. Abbott 3605 Crossland Avenue Baltimore, Md. 21213 pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must 1 N Burial 2 Cremetion 3 Re 4 Donation 5 Other (Specify) 5/1/95 Timonium Maryland Dulaney Valley Mem. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Knight Jr Milton, JA hours after death. Leonard J. Ruck, Inc. n by the fr 5305 Harford Road Baltimore, Md. 21214 medicai 23. PART I. Enter the diseases or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. filled in by Approximate Interval Between IMMEDIATE CAUSE (Final Onset and Death cremation, the disease or condition resulting in death) STAPHYLOCOCCAL SEPSIS 7 DAYS completely event, OUE TO (OR AS A CONSEQUENCE OF): and corr burial, traumatic CERTIFICATION Sequentially list conditions, 2 DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING 2 prior certificate CAUSE (Disease or injury Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 the after Mental injury, PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS and and AVAILABLE PRIOR TO COMPLETION OF CAUSE any MALIGNANT LYMPHOMA signed Health a 1 TYES 2 NO OF DEATH? Shows ACQUIRED IMMUNE DEFICIENCY SYNDROME 1 YES 2 P NO 6 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IX UNCERTAIN I PHYSICIAN: Dept 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) State HOSPITAL: 1 VES 2 DIO nt 2 - ER/Outpetient 3 -4 Nursing Home 5 Residence 6 Other (Specify) the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED with marked, this 1 Natural
2 Accident 1 YES 2 NO BY death Investigation OR ATTENDING 3 Suicide 28e. PLACE OF INJURY --- At home, farm, street, factory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 99 6 Could not be DIRECTOR: / hours after d item 28 is 4 Homicide COMPLET Item 29a. CERTIFIER 1 DERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date end place, and due to the cause(a) and manner as stated. (Check only one) FUNERAL within 72 I HOSPITAL TO THE HOSPITA
TO THE FUNERAL
DE filed within 72
IMPORTANT: 11 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 40 ginduz D 41410 P04 P hter 5 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOGINDER P. MEHTA, MD ST. JOSEPH MEDICAL CENTER TOWSON, MARYLAND 21204 31. DATE FILED (Month, Day, Year) 8 1995

ABBOTT

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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH 1995 YEAR HOWARD ARP 25, APRIL 02:00 Рм 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. leat birthday) 7. DATE OF BIRTN (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. a. BIRTNPLACE (State or Foreign 1 X M 2 F 543-20-1702 71 Jan. 4. 1924 Idaho 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN THE JOHNS HOPKINS HOSPITAL DIRECTOR Pages 1, 2, 3 BALTIMORE CITY Baltimore City RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore permit. Pikesville 1 YES 2 X NO FUNERAL 10s. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 4742 Belle Forte Road 21208 U.S.A. hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 A YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—It yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, stc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Merried YES, GIVE WAR OR DATES WW 2 1 TES 2 NO Specify: ¥ Specify: 3 🔯 Widowed 4 🔲 Divorced White COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade complet 18. OECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY Defense Manufacturing Elementary/Secondary (0-12) College (1-4 or 5+) 2 Years Engineer Westinghouse 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surneme) notified at Benjamin U. Arp Esther BE Burris 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mary Lou Hamilton P.O. Box 218 Keyser, West Virginia 99 200. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State Must 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State Greenwood Cemetery ☐ Donation 5 ☐ Other (Specify) Palouse, Washington 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Step Loring Byers Funeral Directors, Inc. sans her 8728 Liberty Road Randallstown, MD filled in by the medical 23. PART I. Enter the disesses, or complications that caused the deeth. Do not enter the mode of dying, such as cardisc or respiratory errest, Approximate shock, or heart fellure. List only one cause on each line. ŏ interval Between IMMEDIATE CAUSE (Final Onset and Dasth cremation, the disease or condition 5 D completely Hyponatremia.

JOUE TO (OR AS A CONSEQUENCE OF): event, resulting in death) burial, 3 WKS other traumatic CERTIFICATION Cerebral metastases and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING physician Metastatic lung ca DUE TO (OR AS A CONSEQUENCE OF): 5 MOS CAUSE (Diseese or injury that initisted events resulting in death) LAST aftending the aften Mental h PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMEO? MEDICAL 24b. WERE AUTOPSY FINDINGS Health and AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? any 1 YES 2 NO 1 TYES 2 NO Deer ъ DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🕱 NO 🗌 UNCERTAIN 🗍 **PHYSICIAN:** Dept. 8 has 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) **EXAMINER?** OTHER: 1 TES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Nome 5 Residence 8 Other (Specify) 0 the 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c, INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED marked. with this 1 Natural 2 Accident 1 YES 2 NO BY death After Investigation DIRECTOR: At hours after de item 28 is r 3 Sulcide 28e. PLACE OF INJURY — At home, ferm, street, tectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Nomicide 8 29s. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(s) end menner as stated. FUNERAL I 2 _ MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner ea stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER B 29d. DATE SIGNED (Month, Day, Year) Sherita a. Still, MD M6279 1/25/95 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF GEATN (ITEM 27) (Type, Print) Tower 110 Doctor's Louige Dr. Sherita Hill JHH Baltimore, MD 21287

Par 1250

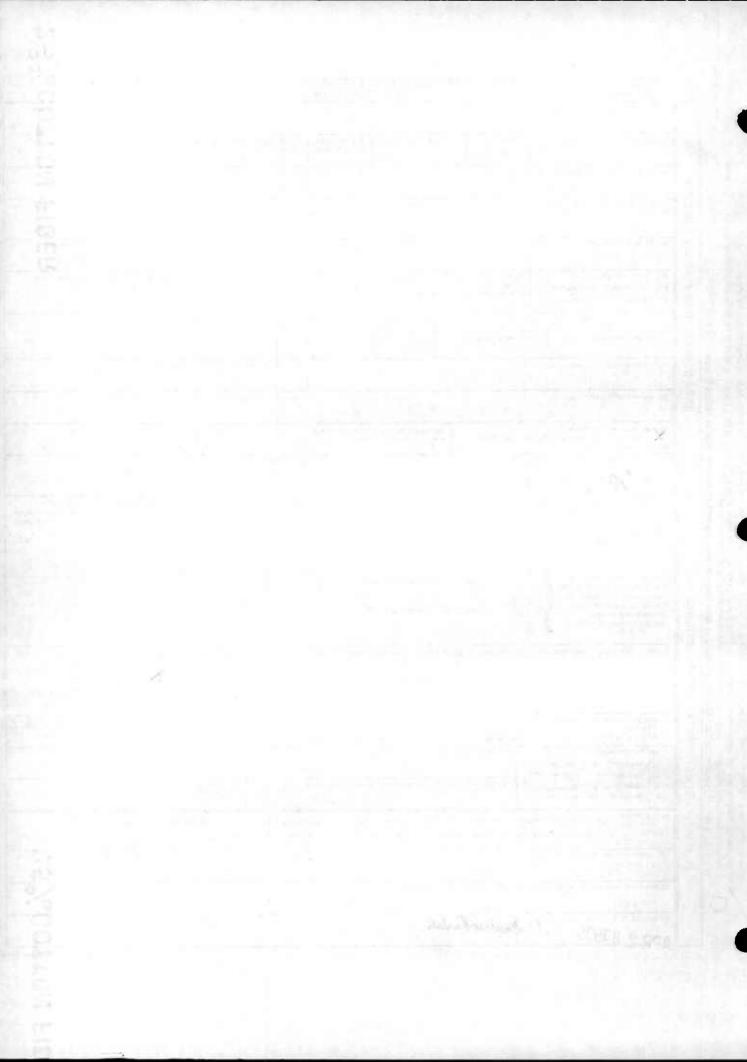
a remark to

FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	Frances Hill Addiso	n		2. DATE OF DEATH DATE 1	25, 19			
COMPLETED BY FUNERAL DIRECTOR		(In yrs. lest birthday) IF (9 YRS. MON	ANDER 1 YEAR OF UNDER 24 HRS. THE DAYS HOURS MIN.	JUNE OF BIRTH	A BII	md.		
	99. FACILITY HAME (If not institution, give street and number) 99. CITY, TOWN DR LOCATION OF DEATH FREDERICK FREDERICK FREDERICK FREDERICK							
	10e. STATE 10b. COUNTY FREDERICK	WN OR LOCATION FREDERICK		10d. INSIDE CITY LIMITS? 1 YES 2 H				
	104. STREET AND HUMBER 10401 A LIBERTY RD.	101. ZIP CODE 21	701	10g. CITIZEH OF WHAT COUNTRY? U.SA				
	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER FORCES? 1 YES	2 ENO	13. WAS DECEMBENT OF HISP It yee, specify-Cuben, Maxi 1 YES 2 NO Spec	В	ACE — American Indian, lack, White, atc.			
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 8+)	(Give kind of work of life. Do NOT use reti	EDENT'S USUAL OCCUPATION kind of work done during most of working to NOT use retried.) URANCE AGENT INSURANCE					
BE COM	17. FATHER'S HAME (First, Middle, Last) CHARLIE A. HILL		18. MOTHER'S NAME (First, Middle, Maiden Sumame) KATIE SMITH					
TO B	19e. INFORMANT'S HAME (Type/Print) MELVIN ADDISON	19b. MAJLING ADD	RESS (Street end Number or Rure A LIBERTY R	D. MOUNT	n, State, Zip Code) PLEASA	NT, MD 2170		
	1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	b. PLACE AND DATE OF DIS			cation - city of freder	Town, State ICK MD		
	21. SIGNATURE OF FUHERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACULTY CARY L. ROLLINS FUNERAL HOME 100 WEST ALL SAINTS ST. FREDER 21701 MARYLA							
CERTIFICATION	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence of):							
	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE DF): DUE TO (OR AS A CONSEQUENCE OF):							
CERT	resulting in death) LAST							
MEDICAL	PART II. Other alguificent conditions contributing to death but not resulting in the underlying cause given			PERFOR	24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FIND AMALABLE PRIOR TO COMPLETION OF CAUTO OF DEATH? 1 YES 2 NO			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)							
YSIC	EXAMINER? 1 YES 2 NO							
ВУ РН	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 2 Accident Investigation	28b. TIME OF INJURY	28c. INJURY AT WORK? M 1 YES 2 ND	28d. DEŞCRIBE HOW I	284. DEŞCRIBE HOW IHJURY OCCURED			
	3 Suicide 5 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street end Number or Rural Route Number. City or Town, Stete)							
COMPLETED	29e. CERTIFYING PHYSICIAH: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner es stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) and menner es stated.							
BE	296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 0417/7				29d. DATE SIGNED (Month, Day, Year)			
유	30. HAME AHD ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 56 TJ Dr. FRED. M.D. 21702							
	31. DATE FILED (Month, Day, Year)	WURE		RAIS II		11 33		

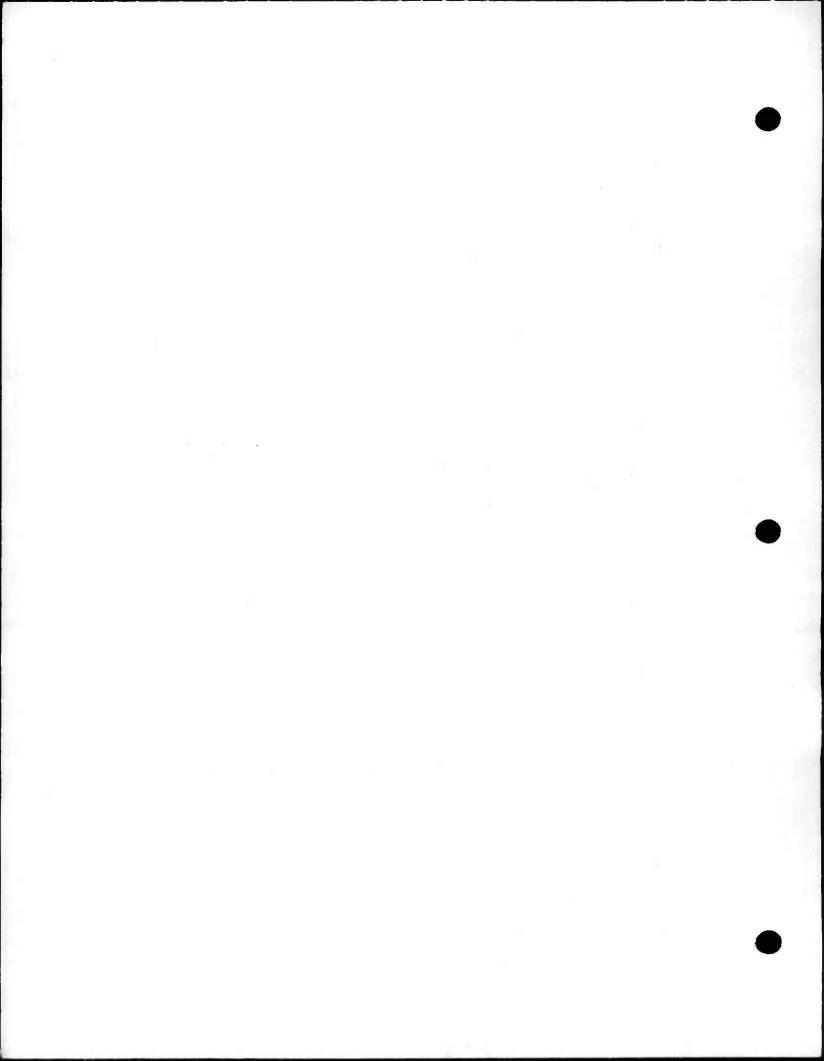
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.



BAI TIMORE MARVI AND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

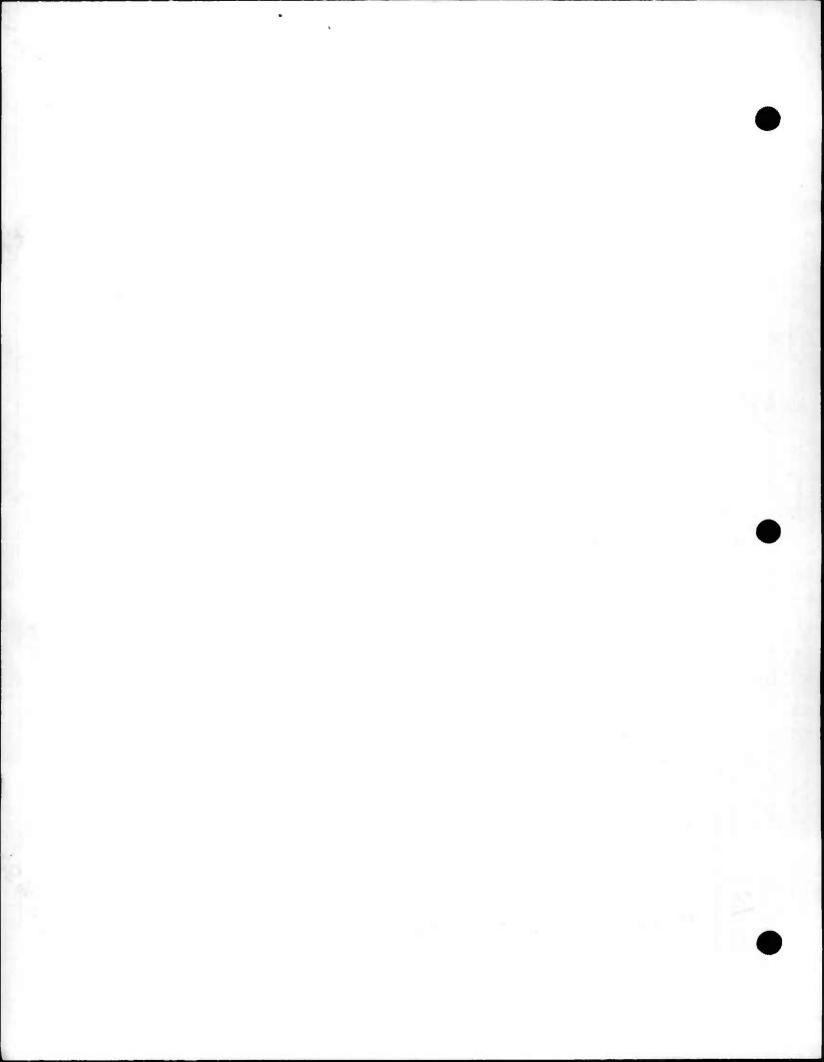
		REGISTRAR	STATE OF MARYLA		RTMENT OF H			HYGIENE REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last) Charlotte	Mary	Bry	an		2. DATE OF	I DAY	YEAR 9:00 Q M		
2, 3 should			V	n yrs. lesi birthday) 97 YRS.	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, Di Jan 19	9, 1898	8. BIRTHPLACE (State or Foreign Country) Germany		
	en on	90. FACILITY NAME (If not institution, give stree Good Samaritan			7.00	or LOCATION OF DE	ATH		9c. COUNTY OF DEATH		
	DIRECTOR	RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCA	TION		10d. INSIDE CITY			
permit, Pages 1,	1	Maryland 100. STREET AND NUMBER	N/A			ltimore (City	10a CITI	LIMITS? 1 🔀 YES 2 🗌 NO ZEN OF WHAT COUNTRY?		
SI.	FUNERAL		Evergreen A			2	21214	Uni	ted States		
LAND ZIZIS-UOZO the hospital or attending physician, detached for use as the burial-frar once.	ETED BY FU	11. MARITAL STATUS 1	2. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 X NO	R yes, sp	ENDENT OF HISPAN ecity Cuben, Mexica 2 X NO Specify	n, Puerto Rica	specify Yea or No— n, etc.)	14. RACE — American Indian, Black, Whita, atc. Specify: White		
or atten		15. DECEDENT'S EDUCAT (Specify only highest grade cor	ripleted)	16a. DECEDENT'S (Give kind of	USUAL OCCUPATH work done during mo se retired.)	ON est of working	16b, KII	ND OF BUSINESS/INC	USTRY		
AND A le hospital o letached for lore.	COMPLE	Elementary/Secondary (0-12)	College (1-4 or 5 +)		łomemaker			N/A			
by the hospit be detached		17. FATHER'S NAME (First, Middle, Last)	udolph Gero	ld		1	ME (First, Midd lbeth (le, Malden Surname)			
retained to 5 should notified	TO BE	19a. INFORMANT'S NAME (Type/Print)	· ·	19b. MAILING	ADDRESS (Street a	and Number or Rural F	Route Number, (City or Town, State, Zip	Code)		
6 may be rector, page 5	۴	Joseph H. Steinme			EVERGRE OF DISPOSITION (No	en Avenu			Md. 21214		
Page 6 ma al director, p		1 X Buriel 2 Cremetion 3 Remova 4 Donation 5 Other (Specify)	trom Stata came	Holy Red	leemer Ce	em. 4/29		Baltimo			
death. funer		21. SIGNATURE OF FUNERAL SERVICEULICEN Multon	Enight	knight Jr	5305	Harford	Rd. B	nard J. Ruc altimore	, Md. 21214		
within 24 hours npletely filled in cremation, or n		23. PART i. Enter the disease or conshock, pr heart fellure. Lie IMMEDIATE CAUSE (Finei disease or condition resulting in death)	t price to the course on each of the course of	hemis	phere			or reepiratory arr	Interval Between Onset and Death		
th certificate be execute rending physician and country li Hygiene prior to buria or other traumatic	CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Heavt failure DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.									
that the ed by the th and M any Inju	MEDICAL	PART II. Other eignificent conditions of	ontributing to deeth bu	t not reculting	In the underlying	g ceuse given in i		PERFORMED? YES 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
e law requires has been sign Dept. of Heal	AN: M	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF	DEATH YE	S NO R	UNCERTAIN			1 TYES 2 NO		
N: The law ficate has State Dep item 23	SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	QSPITAL:		OTHER:						
PHYSICIAN: The this certificate with the State	РНУ	27. MANNER OF DEATH	Inpatient 2 ER/Outpat 28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. INJ	● 5 ☐ Residence : URY AT RK?		BE HOW INJURY OCC	URED		
ATTENDING PHYSICIAN: The ECTOR: After this certificate his safter death with the State Din 28 is marked, or Nem	B≺	1 Natural 5 Pending Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY -		M 1 🗆 1	rES 2 NO	201 004710	At /De-at and think	2		
OR ATTENDING DIRECTOR: After hours after death item 28 is ma	ETED	4 Homicide 8 Could not be determined	building, atc. (Specifi	(y)			City or To	wn, State)	or Rural Route Number,		
世 32年	COMPLI		N: To the best of my knowle						ed. s cause(s) and manner as stated.		
TO THE HOSPI TO THE FUNEF be filed within	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER -	PMI).		29c. LICENSE NUM	239 4	29d. DATE	ESIGNED (Month, Day, Year) PUT 27 - 95		
1	-	30. NAME AND ADDRESS OF PERSON WHO &	FUN HOSD	-1 1		ch Raw	on II.	d - Post	Timula H.D.		
2		31. DATE FILED (Morith, Day, Year) APR 2, 8 1995	32. REGISTRAR'S SIGNAT		00, 0	21. 1.00	ZA I TO!	241	- MINA		



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MONTH 04 26 MARGARET BELL 62,00 4 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Fore) (Month, Day, Year) 07-17-14 1 🗆 M 2 📜 F 213-18-6394 80 MD. the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR CAMDEN YARD N/H BALTIMORE N/A 10e, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD. N/A BALTIMORE 1 📉 YES 2 🗌 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1217 W. FAYETTE STREET 21223 USA hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuben, Mexican, Puerto Ricen, atc.)

1 YES 2 NO Specify: 1 Never Married 2 Merried Specify: WHITE 8 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 180. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) NK UNK UNK 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 100 UNK UNK 띪 notified a 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 CARLA WAAFIELD 861 PARK AVE. BALTO. MD. 21201 be 200. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must
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 Burlel
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 4
 □ Donetion
 5
 □ Other (Specify)
 ZION CEMETERY 04-28-95 LANSDOWNE, MD. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE. 22. NAME AND ADDRESS OF FACILITY ALBERT P. WYLIE F/H PA 638 N CILMOR STREET medicai 23. PART I. Enter the diseases, or compilications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert feliure. List only one ceuse on each line. physician and completely filled in by ne prior to burial, cremation, or remo **Approximate** Interval Between **IMMEDIATE CAUSE (Finel** Onset end Daath event, the disease or condition_ Preumonea resulting in death) executed with A CONSEQUENCE OF): Atraceanial traumatic montle CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING death certificate be CAUSE (Disease or Injury other signed by the attending ph Health and Mental Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initiated evente resulting in deeth) LAST 5 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? PERFORMED? any 1 YES 2N NO 1 TES 2 NO been at. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square certificate has be PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) The EXAMINER? HOSPITAL: 1 YES 2 NO HOSPITAL OR ATTENDING PHYSICIAN: 'FUNERAL DIRECTOR: After this certifica within 72 hours after death with the Sta 1 Dipatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 28c. INJURY AT 28b. TIME OF 26d. DESCRIBE HOW INJURY OCCURED marked, 18 Natural BY 1 YES 2 NO 2 Accident Investigation 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, lectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is COMPLETED 6 Could not be 4 Homicide determined Item 29e. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the lime, date end place, end due to the ceuse(e) end menner ee stated. Ξ TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II basis of examination end/or investigation, in my opinion, death occursd at the time, date end place, end due to the ceuse(s) and menner es stated. 29b. SIGNATURE AND STILE OF CERTIFIE 29d. DATE SIGNED (Month, Day, Year) BE 29c. LICENSE NUMBER D32158 27 5 OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (1706, Print 30. NAME AND ADD arikh MD N Eutaw St, Baltimore MD 2/201 Stute 407 31. DATE FILED (MONTH), Day, 1887)
A DD 2. 8 1995



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within our steer death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit pe	ath \	**************************************
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ITEMS: 1.10b,10c,10d, PER F.H. FILM G-722 4/28/95 t.t

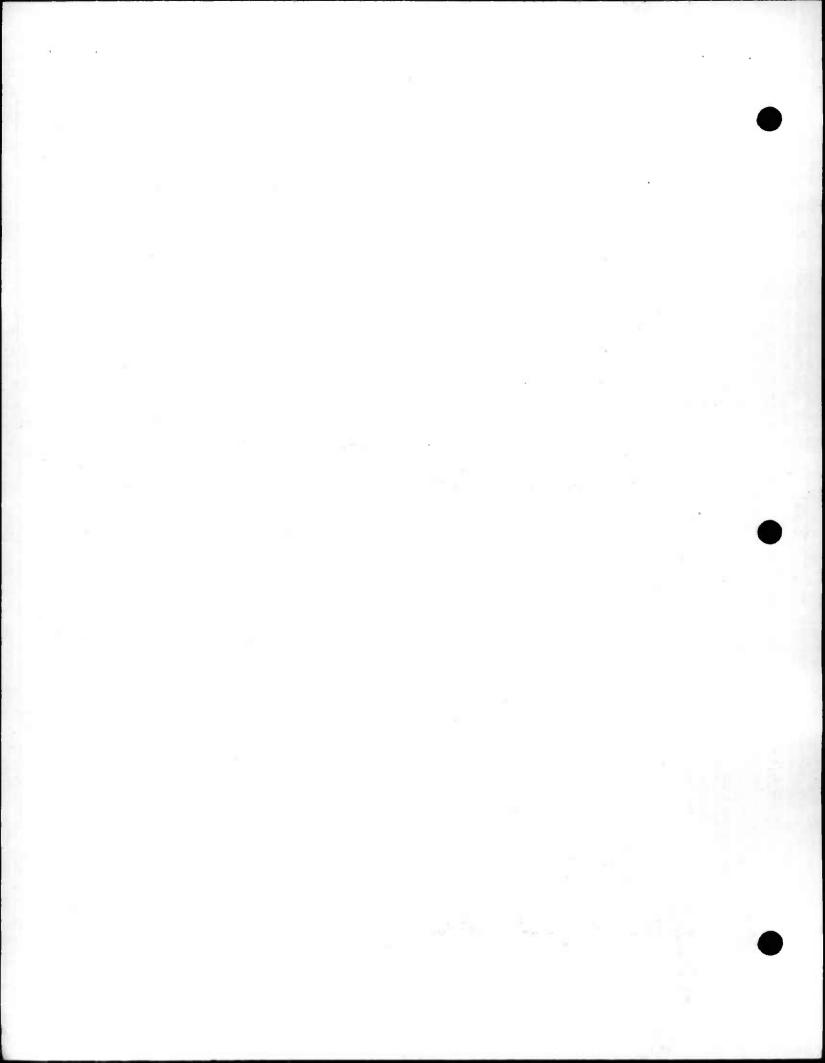
FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR		C	ERTIFI	CATE C	OF D	EATH	MEN	REG. NO).		
	1. DECEDENT'S NAME (First, Middle, Last)	,						2. [DATE OF DEATH		3	. TIME OF DEATH
	Bauer, Mar	tima 11	ARTINA	BAUER				A	PRIL 2	5 /	YEAR 99	1815
	4. SOCIAL SECURITY NUMBER		GE (In yrs. Is		IF UNDER 1 YE		F UNDER 24 HRS.	7.0	ATE OF BUTTH			ACE (State or Foreign
	219-10-6831	1 🗆 M 2 KF	86	YRS.	MONTHS DAY	WB H	HOURS MIN.	Ž	Month, Day, Year)	1908	Gern	nany
<u> </u>	98. FACILITY NAME (It not institution, give s Church Home Hos)						timore	OEATH		9c. COUN	TY OF DEA	ТН
CTOR	RESIDENCE OF DECEDENT							-		1 1	//\	
DIRE(Maryland 106. COUNT		SEDALE	OCATIO		time	re City			Dd. INSIDE CITY LIMITS? YES 2 NO		
FUNERAL	100. STREET AND NUMBER 5519 Daybreak To	errace				101. Z	IP CODE	21	206			at country? States
B	11. MARITAL STATUS 1 Never Married 2 Married 3 M Widowed 4 Divorced	12. WAS DECEDENT EVI FORCES? 1 Y IF YES, GIVE WAR O	ES 2	RMED [NO	If yes	s, speci	OENT OF HISP by Cuban, Maxi XNO Special	Ican, Pu	RIGIN? (Specify Yearto Rican, etc.)	a or No—	Black, \	- American Indian, White, atc. White
	15. DECEDENT'S EOU (Specify only highest grade	CATION completed)	(1	ECEDENT'S U	ork done during	PATION a most o	of working		16b. KIND OF BU	SINESS/INDU	JSTRY	
APLET	Elementary/Secondary (0-12) 6 Years	College (1-4 or 5+)	life	ь Do NOT изв Homema	retired.)				Ou	n Hom	e	
COMPL	17. FATHER'S NAME (First, Middle, Last)					1			irst, Middle, Malder	Sumame)		
BE	Joseph Oesterle						Elizal					
2	190. INFORMANT'S NAME (Type/Print) Helen B. Miller		11						Number, City or Tow Raltim			2and 2120
	204. METHOD OF DISPOSITION			AND OATE OF	DISPOSITION	N (Name	of			OCATION - C		
	1 & Burlet 2 Commention 3 Removal trom State 4 Donation 5 Other (Specify) Baltimore, 22. NAME AND ADDRESS OF FACILITY Duda—Ruck Funeral Home of Dunda									re, N	(D	
	* hal W	Fish	/		22. NAM DUG 792	da⊸i 122 U	address de l Ruck Fl Vise Al	racility UNE	ial Home Dundal	of Di	undal 212	2k, Inc.
CATION	disease or condition resulting in death) Discrete to the property of the conditions, as a consequence of: Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
CERTIFIC	CAUSE (Disease or Injury that initiated eventa resulting in death) LAST	DUE TO (OR A	AS A CONSE	CONSEQUENCE OF):								
CALC	PART II. Other aignificant condition	a contributing to deal	h but not	raaulting in	tha under	lying c	ause given i	in Part	i. 24a. WAS AP			ERE AUTOPSY FINDIN
MEDIC	Diaser.	es mellis		ecua	e dus	ul	cer		1 TYES	1	0	VAILABLE PRIOR TO OMPLETION OF CAUS F DEATH?
ž	DID TOBACCO USE							10V	D			_ res 2 _ No
ICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER:	8. PLAC	E OF DEATH	Check on	nly one)			
S I	1 TYES 2 NO	1 npatient 2 ER/		3 DOA	4 Nursing	Home	5 🗆 Rasidenc	a 6 🗆	Other (Specify)			
Y PHY	27. MANNEB OF DEATH 1 Netural 5 Pending 2 Accident Investigation	26s. DATE OF INJU (Month, Day, Ye		28b. TIME INJU	RY	WORK	Y AT ? 2 □ NO	28d.	DESCRIBE HOW	INJURY OCCI	URED	
TED B	3 Suicide 6 Could not be determined	28s. PLACE OF INJ building, atc. (28a. PLACE OF INJURY — At homa, farm, street, tactor building, atc. (Specify)			ctory, office 28f. LOC			St. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
COMPLET		CIAN: To the best of my k										nd manner as stated
	296. SIGNATURE AND TITLE OF CERTIFIED	1 Que	0.5	Cas ex	alit	_ 2	OC. LICENSE N	UMBER	6	29d. DATE	720 11	fonth, Day, Year)
2	30 NAME AND ADDRESS OF PERSON WH	O COMPLETEO CAUSE OF	DEATH (TE	/	- 11	.19	Prop	かい	see A	10		25,199
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S S	PA	oad	way	1	igne	11D	see 14	D	X/2	3/
	APR 2 8 1995	ali d'avoler	Rarbell	,								

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may	TO THE PHREAL DIRECTOR After this certificate has been signed by the attendion physician and completely filled in by the funeral directors
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		1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF HEAD		TAL HYGIENE REG. NO.					
		1. DECEDENT'S NAME (First, Middle, Last) DORIS MAY BO	HON			2. D.	ATE OF DEATH DAY	year 4:00 PM M				
		4. SOCIAL SECURITY NUMBER 220-22-4353 A	4 🗆 ** 6 🖼 **	(In yrs. lest birthday) YRS.		UNDER 24 HRS. 7. DA	ATE OF BIRTH forth, Day, Year)	8. BIRTHPLACE (State or Foreign Country)				
3 should		9a. FACILITY NAME (If not institution, give s	00	3 ma.	9b. CITY, TOWN OR LO			West Virginia OUNTY OF OEATH				
1, 2, 3	BY FUNERAL DIRECTOR	3607 Courtleig	h Dr.		Randalls	town	Ва	ltimore County				
		10e. STATE 10b. COUNTY Florida St. J			Y, TOWN OR LOCATION		-	10d. INSIDE CITY LIMITS?				
burial-transit permit. Pages		100. STREET AND NUMBER	ohns Co.	S1	t. Augusti		10g. C	1 YES 2 NO				
transit		1700 Woodlawn R				095		USA				
as the burial-		1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 TYES IF YES, GIVE WAR OR D.	2 XNO	If yes, specify	ENT OF HISPANIC OR Cuben, Mexican, Pue NO Specify:	IGIN? (Specify Yes or No- rto Rican, atc.)	- 14. RACE American Indian, Black, White, etc. Specify: White				
r use as	ETED	15. DECEDENT'S EDU (Specify only highest grade	completed)	16a. DECEDENT'S (Give kind of w life. Do NOT us	USUAL OCCUPATION work done during most of	working	16b. KIND OF BUSINESS/	INOUSTRY				
detached for use	OMPLE	Elementary/Secondary (0-12) 10th Grade	College (1-4 or 5+)	Waitress			Kitchen	hen				
be deta	၂၀၂	17. FATHER'S NAME (First, Middle, Last) George H. Whetse	011		18. MOTHER'S NAME (First, Middle, Malden Surname) Ruth Whetsell							
5 should notified	TO BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street and No		letsell fumber, City or Town, State,	Zip Code)				
page 5 be no	F	Mrs. Barbara Nel:					dallstown,					
the funeral director, page 5 should be yeal. al examiner must be notified at		1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Reme 4 ☐ Donation 5 ☐ Other (Specify)	oval from State _cem	netery, crematory or of aplewood	of oisposition (Name of her place) Cemetery	1	-29 Kingwo	- City or Town, State				
funeral di examiner		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		Loring I	Byers Fun						
by the fu moval.		23. PARTU. Enter the diseases, or o	Equel 1	d the death Don	8728 Lit	erty Rd.	Randal1st	errest, Approximate				
ompletely filled in by the II, cremation, or removal event, the medical	CERTIFICATION	interviores indext, or neart failure. List only one cause on each line. iMMEDIATE CAUSE (Fine) disease or condition resulting in death) a. Due to (on AS A CONSEQUENCE OF):										
ending physician and c Hygiene prior to buria or other traumatic		Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	c	CONSEQUENCE OF				2 mo.				
y and	EDICAL	PART II. Other aignificent condition	a contributing to deeth b	put not resulting in	n the underlying ceu	use given in Part i	24a. WAS AN AUTOPS PERFORMED? 1 YES 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
Dept. of Heal	AN: M	DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	F DEATH YE	S I NO B U	INCERTAIN 🗆		1 TYES 2 NO				
cate has State De Item 2	SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO	HOSPITAL:	26. PLACE OF DEAT	OTHER:							
s certifi th the od, or	PHYS	27. MANNER OF DEATH	1 Inpatient 2 ER/Outp 28a. OATE OF INJURY (Month, Day, Year)	28b. TIME			nther (Specify) DESCRIBE HOW INJURY C	OCCURED				
After this leath with marked	BY	1 Natural 5 Pending 2 Accident Investigation		INJU	M 1 TYES							
DIRECTOR: After this certificate has been signed hours after death with the State Dept. of Health Item 28 is marked, or Item 23 shows an	ETED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, atc. (Spec	cify)	reet, lactory, office	281, L	OCATION (Street and Numb City or Town, State)	ber or Rural Route Number,				
로 유 =	COMPLE		CIAN: To the best of my knowl R: On the basis of examination					stated,				
P fied	BEO	29b. SIGNATURE AND THE OF CERTIFICE	5		29c.	LICENSE NUMBER	/ 29d. D.	MATE SIGNED (Month, Day, Year)				
P 2 2	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE OF OE	ATH (ITEM 27) (Туре,	Print)	D2316	6	9/23/93				
101		Greater Y. Alos	TOLIDES M	D. 2	O Crossr	oads D	r. Suite	10 21117				
		APR 2 8 1995	in Durber Ran	CUL								

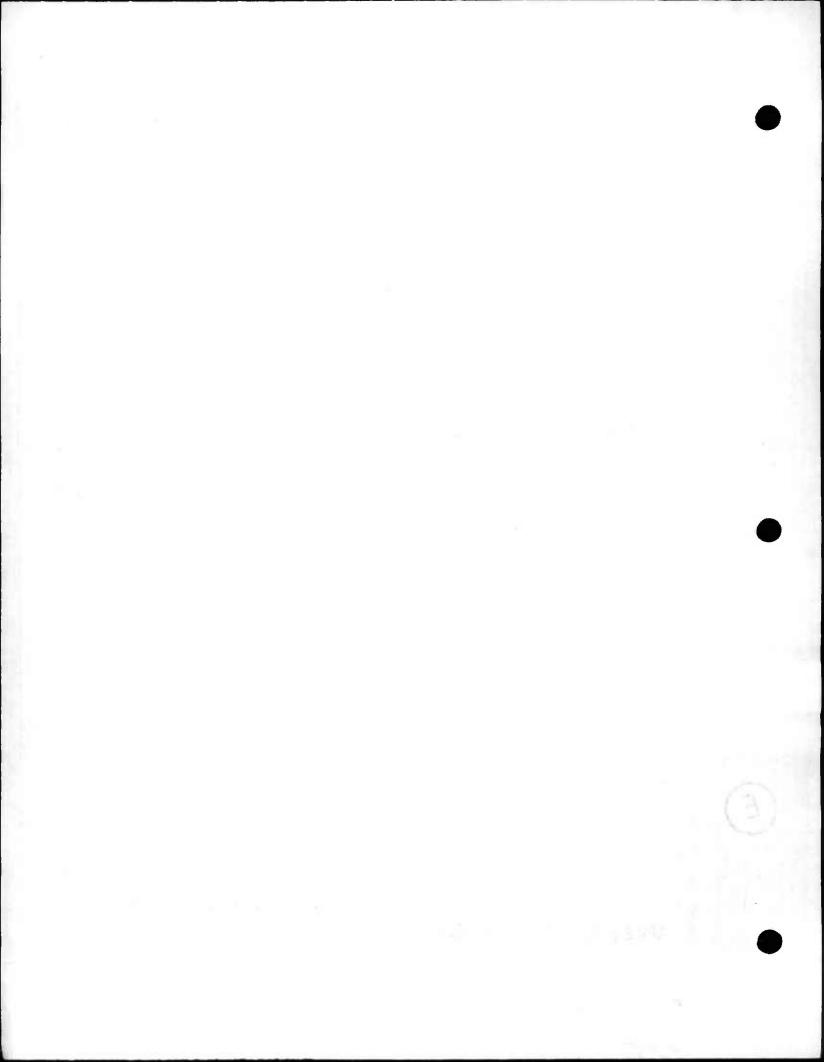


PARSONN: The law requires that the death certificate be executed within-res hours after death. Page 6 may be retained by the hospital or attending physician.

The law requires has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should death with the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

It marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 GION OF VITAL RECORDS, P.O. BOX 68760 TO THE FUNE TO THE

	FOR STATE REGISTRAR	STATE OF MARY	LAND / DEP/ CERTI	ARTMEN'	OF H	IEALTH DEA	AND TH	MENT	AL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)								E OF DEATH		- 77	3. TIME OF DEATH
	JEREMY	MICHAE	L _	BRAN	DJE	S		0.4			95	14:30P M
	4. SOCIAL SECURITY NUMBER		E (In yrs. last birthda	MONTHS	DAYS	IF UNDER	MIN.		E OF BIRTH	Country)		PLACE (State or Foreign
	220-02-9407	1 XM 2 F	21 YRS				1.25	_	1 . 20 , 1	973	M	äryland
DIRECTOR	99. FACILITY NAME (If not institution, give : AMERICANA MOTO RESIDENCE OF DECEMENT				CI		EATH			NTY OF D	STER_	
٣ ا	10a. STATE 10b. COUNT		10c. 0	CITY, TOWN	OR LOCAT	ION						10d. INSIDE CITY
		altimore		E	sse	x						LIMITS?
ا ۲	10e. STREET AND NUMBER				101	ZIP COD				10g. CIT	IZEN OF V	HAT COUNTRY?
FUNERAL	618 North W						2122				US	A
B	11. MARITAL STATUS 1 Sever Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 1 YES	8 2 NO	2 NO If yes, specify Cuben, Mexican					ilN? (Specify Yes o Rican, atc.)	Speci	- American Indian, t, white, etc. by: White	
C C	15. OECEDENT'S EDU (Specify only highest grade	ICATION	16e. DECEDENT	'S USUAL O	CCUPATIO	ON	-	10	Sb. KIND OF BU	INESS/INC		MILLOE
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NO1	of work done use retired.)					,, c		~	
	U.N.K,		1	oadi	ng	Plar	1es		0.8	.Air	Ca	rgo
٥ ا	17. FATHER'S NAME (First, Middle, Last)					18. MOT	HER'S NA	ME (First	, Middle, Maiden	Sumame)		
BE	Daniel Brand	jes							Delp			
2	19e. INFORMANT'S NAME (Type/Print)	_							mber, City or Tow			
	Karen Schlege						cres	-	-			d.21076
	1 Denition 5 Other (Specify)	noval from State Co	b. PLACE AND DAT	r other place)			/			CATION —		71 - 14 - 15 - 15 - 15 - 15 - 15 - 15 - 1
	21. SIGNATURE OF FUNERAL SERVICE LIN	CENSES	ardens			h 4/			R	ossv	<u>7111</u>	e Md.
	DR TIL		1//						al Ho	me c	f E	ssex
	1. Terry	Conne	lly	_ 3	00	Mace	Av	re.	Balti	more	6M	
											Approximeta interval Between Onset and Daath	
ERITICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
ALC	PART II. Other significent condition	s contributing to deeth	but not resultin	g in the ur	deriying	ceuse (given in	Pert I.	24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
PHYSICIAN: MEDIC				_					1 TYES 2	□ NO		COMPLETION OF CAUSE OF DEATH?
ž	DID TODA COO LIST CO.											1 TES 2 NO
Z	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUSE (UNC	ERTAII	<u> </u>				
2	EXAMINER?	HOSPITAL:	26. PLACE OF OR	OTHE	₹:							
2	1 SYES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Ou		4 Nur	eing Hom 28c. INJ		sidence		er (Specify) [OTE		
	1 Natural 5 Pending	(Month, Day, Year)		NJURY M	1 1	RK?	NO		Wojec			ME
2	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJUR	IY — At home, farm		_				CATION (Street			
COMPLEIED	4 Homicide determined	building, etc. (Sp	еспу)		L T WILL			Cit	y or Town, State)			
ן נ	290. CERTIFIER 1 CEPTIEVING BUYSICIAN TO IDEAN OF THE PROPERTY HORSE OF THE PROPERTY HOR									13109 0131013		
į	29. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner ee stated. 2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) and manner ee stated.									and manner se stated		
	291 SIGNATURE AND TITLE PA CERTIFIE								2112 P1000, 011			
#	Wording Mel	A/ A 1	R			_	ENSE NUM		ı			(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WH	1.00		pe, Print)		0	Cal	M.E.		A	PRII	26.1995
	MARYANIOS A.	Loron 1	11 Peni		eet	, в	alt	imo	re, Ma	ryl	and	21201
	31. DATE FILEO (Month, Day, Year) APR 2 8 1995	32. REGISTRAR'S SIG										



1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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1 3	1. DECEDENT'S NAME (First, Middle, Last	0	;			2. DATE OF DI	EATH DAY	YEAR	L TIME OF OEATN	
	4. SOCIAL SECURITY NUMBER	S. SEX 6. AGE	BOBS	3IN		Apr	23 1995		2:30 pm	
1 8	047-18-5692-A		(In yrs. last birthday) 69 YRS.	MONTHS D	EAR IF UNDER 24 HRS. AYB HOURS MIN.	7. DATE OF BI (Month, Day,	Year)	Country)	ACE (State or Foreign	
	9e. FACILITY NAME (If not institution, give		0,	96. CITY, TO	OWN OR LOCATION OF		16,1925	NTY OF OEA	ecticut	
TOR	Saint Joseph Med	ical Center			wson, Mary			altimon		
DIRECTOR	10e. STATE 10b. COUN	n Altimore	10c. CIT	Perr	ocation y Hall			12	od. INSIDE CITY LIMITS?	
AL	10e. STREET AND NUMBER			101. ZIP CODE			10g. CiT		YES 2 X NO	
8	34 Bangert Aver				21128			U.	S.A.	
BY FUN	11. MARITAL STATUS 1 Never Merried 2 X Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 [X] YES IF YES, GIVE WAR OR I	2 NO	If ye	B DECENDENT OF NISPA DE, specify Cuban, Mexic YES 2XXNO Specify	exican, Puerto Rican, atc.) Black			- Armerican Indian, White, atc. White	
9	15. DECEDENT'S ED (Specify only highest grad	UCATION	16a. DECEDENT'S	USUAL OCCU	IPATION	16b. KIND	OF BUSINESS/IN	DUSTRY	WILLEC	
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+) 4	Electric	se retired.) (Dwner gineer	Ins	trumenta	ation	Company	
BE CO		bbin		16. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Fay						
5	19a. INFORMANT'S NAME (Type/Print) Mary E. Bobbin	(wife)			treet end Number or Rura t Avenue,			2112	0	
	26a. METHOD OF DISPOSITION 1 A Burlel 2 Cremation 3 Rec	20	b. PLACE AND DATE	OF DISPOSITIO			20c. LOCATION —			
	4 Donation 5 Other (Specify)	S1	metery, crematory or o	i's Chi	urch Cem.	4/27			laryland	
	21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE		Sch	me and address of F imunek Fun 5 Belair R	eral Ho	mes, Ind	C.	1006	
	23. PART I. Enter the diseases, or	complications that cause	d the deeth. Do	not enter the	mode of dying, au	ch as cardiac D	r respiratory ar	MD Z	1 Z 3 b	
	IMMEDIATE CAUSE (Final disease or condition	LUNG CANC	eech line.						Interval Between Onset and Death	
	resulting in death)	DUE TO (OR AS	A CONSEQUENCE O	•						
NO.	Sequentially list conditions,	b. ASPIRATION	A CONSEQUENCE OF						DAYS	
CAT	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury		OCYTOPENIA, HEMORRAGE							
CERTIFICATION	that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):									
- 11	PART II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE									
EDICAL							YES 2 NO	, A	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?	
ME	212 722 4 662 4127 624								YES 2 NO	
AN	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT			и 🗆				
SICI	EXAMINER?	HOSPITAL:		OTHER:	Home 5 - Residence	6 Other /Son	NAS es			
PHYSICIAN	27, MANNER OF OEATN	28e. DATE OF INJURY (Month, Day, Year)	26b, TIM		: INJURY AT WORK?		HOW INJURY OC	CURED		
B	Natural 5 Pending Accident Investigation	26. 81 105 05 10 11 11			YES 2 NO					
ETED	3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY building, etc. (Spe	Y — A1 home, farm, s icify)	street, factory,	office	281. LOCATION City or Town	(Street and Number n, State)	or Rural Rou	te Number,	
COMPL		SICIAN: To the best of my know ER: On the basis of examination							nd manner se stated.	
w II	29b. SIGNATURE AND TITLE OF CERTIFIE				29c. LICENSE NU				onth, Day, Year)	
TO B	C XX	7 2%	di,	MD	D 44722		▶ A	1/23/0	15	
- 1	30. NAME AND ADDRESS OF PERSON W				AADVI AND A	MAAA				
	ROXAN SAIDI M.D. 31. DATE FILED (Month, Dey, Year)	32. DEGISTRANS SIGN	IATURE	OUN, K	MARTLAND 2	a 204	.			
	APR 2 8 1995 July	32. DEGISTRANS SIGN	Ц							
									DHMH-16 Rev 1/8	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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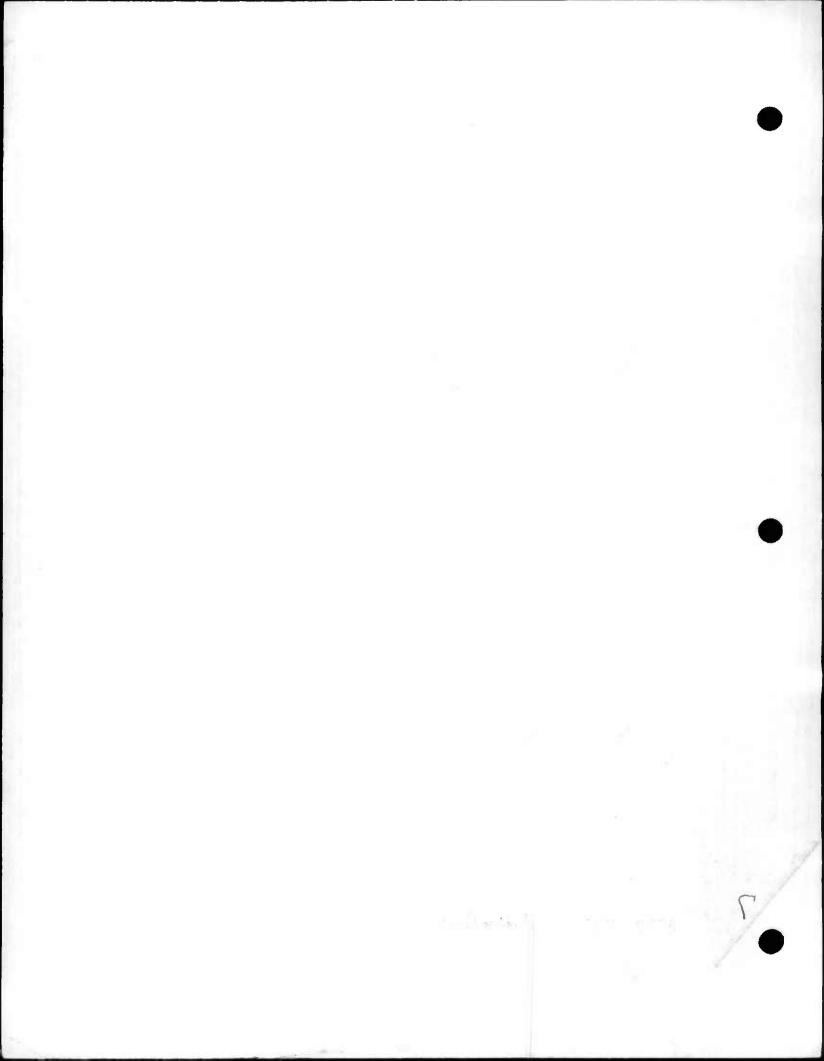
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ROXAN SAIDI M.D. 1620 YORK ROAD TOWSON, MARYLAND 21204

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	AN:	tifica	e St	Dr 10	
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospi	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	١
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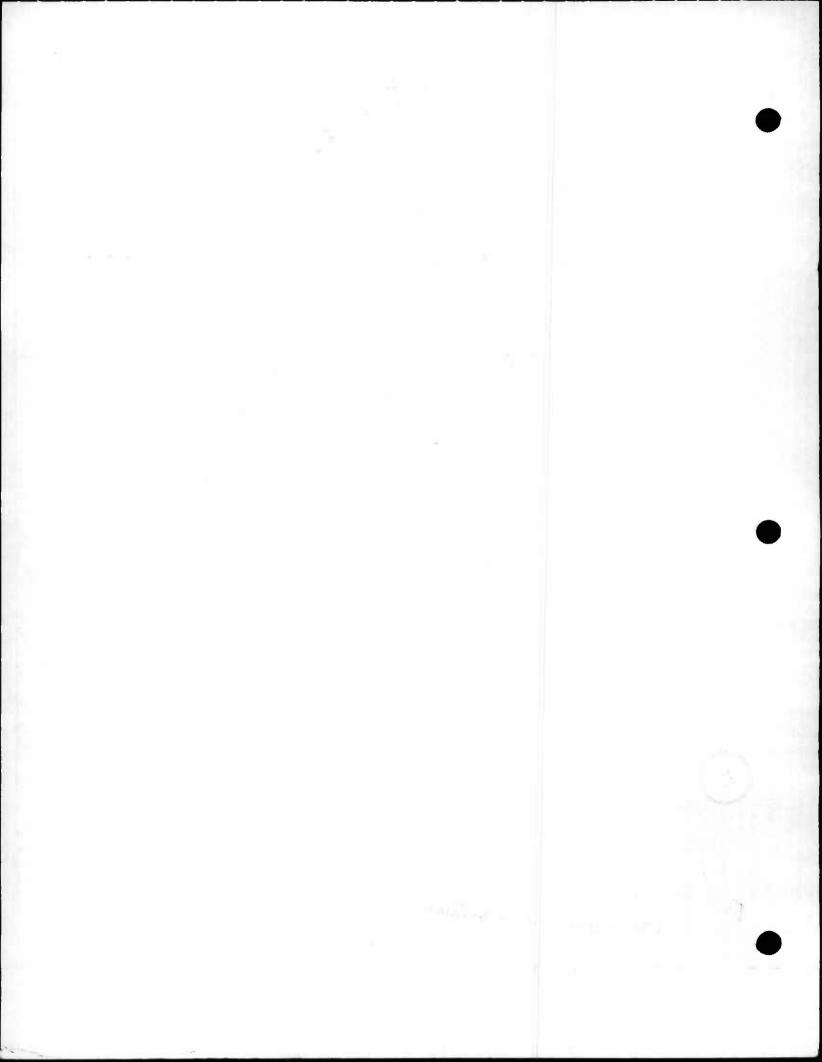
31. APR 2 8 1995

							(,	35	13043		
	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGIE					
	1. DECEDENT'S NAME (First, Middle, Last) MARY	JOAN	B	DESHO	RE	2. DATE OF DEATH	25°	_YEAR	O6:10 Am		
	4. SOCIAL SECURITY NUMBER 212-40-7973	1 🗆 M 2 🗡 F	in yrs. last birthday) 3 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Aug. 11,		8. BIRTHPI Country)	ACE (State or Foreign		
OR	90. FACILITY NAME (# not institution, give s Good Samaritan				imore			NTY OF DEA			
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT	Υ	10c. CIT	Y, TOWN OR LOCAT	ION			T i	ad Bigins City		
RIG	Maryland	N/A			timore			10d. INSIDE CITY LIMITS? 1 X YES 2 NO			
FUNERAL	10s. STREET AND NUMBER			101	ZIP CODE		10g. CITI		AT COUNTRY?		
NEF	3627 Lyndale Ave				21213			U. S.	. A.		
```	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR D.	2 X X 10	13. WAS DEC If yes, spi 1 YES	14. RACE - Black, 1 Specify:	American Indian, White, etc.					
9	15. DECEDENT'S EDU (Specify only highest grade	ICATION	16a. DECEDENT'S	USUAL OCCUPATION	DN .	16b. KIND OF E	USINESS/INC	DUSTRY	WILLE		
COMPLETED	Elementary/Secondary (0-12) 11th Grade	College (1-4 or 5+)		work done during mode retired.)  Person	st or working	Do.	_ 4 1				
O	17. FATHER'S NAME (First, Middle, Last)		Dates	reison	16. MOTHER'S NA	Ret					
BE C	Phillip Michael					Dempsey	,				
TO E	190. INFORMANT'S NAME (Type/Print)  Donna Boeshore (I	Daughter)				Route Number, City or 1			92110 fornia		
	Donna Boeshore (Daughter)  3098 Rue D'Orleans #216, San Diego, Califo  20a, METHOD OF DISPOSITION 1 M Burlal 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)  20b. PLACE AND DATE OF DISPOSITION (Name of cometery, cremetory or other place) Gardens of Faith  4/28 Baltimore, Ma										
	21. SIGNATURE OF FUNERAL SERVICE LIC		ardens	22, NAME AN	D ADDRESS OF FA	CILITY		ore, r	laryland		
	· Willest			3331	Brehms 1	neral Hom Lane, Bal	timore		21213		
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart fellure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  S. UPPER GI BLEED, COAGULOPATHY SERVS  DUE TO (OR AS A CONSEQUENCE OF):										
MOIT	disease or condition resulting in death)  s. UPER GI BLEED, COAGULOPATHY SERVS ONE  DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	CAUSE (Disease or Injury that Initiated events resulting in death) LAST  CAUSE (Disease or Injury that Initiated events resulting in death) LAST										
- 1	PART II. Other significent condition	ns contributing to deeth b	ut not resulting i	n the underlying	ceuse given in	Part I. 24a, WAS	N AUTOPSY	24h W	ERE AUTOPSY FINDINGS		
MEDICAL							ORMED?	AN Ci	ALABLE PRIOR TO OMPLETION OF CAUSE F DEATH?  YES 2 NO		
ż	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YE	S NO	UNCERTAIN	<u> </u>					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL. EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	H (Check only one) OTHER:							
14S	1  YES 2 NO	1 Inpatient 2 ER/Outp		4 - Nursing Home		6 Other (Specify)					
ВУ РЬ	1 Natural 5 Pending Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIMI	URY WOI		28d. DESCRIBE HOV	INJURY OCC	CURED			
	3 Suicide a Could not be determined	28e. PLACE OF INJURY building, atc. (Spec	— At home, 1erm, s						te Number,		
COMPLETED		ICIAN: To the beat of my knowl							nd manner ee stated,		
296. SIGNATURE AND TITLE OF CERTIFIER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. DATE SIGNED (Month, D											
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE			P 0	1238	A	phl	25,95		
	D. JILLAPARLI	, GOOD SA	MAKITA	W 1503	PITAL,	BACTIN	OKE	MD	21239		
	TAPR 2 8 1995" Jul	2 REDISTRAR SIGN	HAE .								



DIVISION OF VITAL RECORDS, P.O. BOX 68760  TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with TO THE FUNERAL DIRECTOR After the certificate has been signed by the attending physician and complete be filed within 72 hours four the time State Dept. of Health and Mental Hydrene prior to burial, cren
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		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF	HEALTH AND	MENTA	L HYGIENE REG. NO.		
		1. OECEDENT'S NAME (First, Middle, Last GOTHUGE		halter	17		2. DATE	OF DEATN		3. TIME OF DEATH  5 45 A M
Þ		4. SOCIAL SECURITY NUMBER 117-05-4175	1 🗆 M 2 💢 F 8 C	(In yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	Apri	OF BIRTH h, Day, Year) .1 25,		BIRTNPLACE (State or Foreign Country)  New York
1, 2, 3 should	DIRECTOR	Suburban Hospi				hesda	EATH		9c. COUNTY Mont	of DEATH GOMERY
permit. Pages 1,		10a. STATE 10b. COUN	ntgomery		v, TOWN OR LOC lver S					10d. INSIDE CITY LIMITS? 1 YES 2 XNO
S.	FUNERAL	100. STREET AND NUMBER 1111 Universit	y Blvd. Wes	st		101. ZIP CODE 20902			-	S.A.
ding physician. the burial-transit	PLETED BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 TYES IF YES, OIVE WAR OR DA	2 🔼 NO	If yes,	ECENDENT OF HISPA specify Cuban, Mexico ES 2 NO Specif	an, Puerto I	i? (Specify Yea Rican, atc.)	or No — 14.	RACE — American Indian, Black, Whita, atc. Specify: White
hours after death. Page 6 may be retained by the hospital or attending physician, bed in by the funeral director, page 5 should be detached for use as the burial-tran or remonal.  medical examiner must be notified at once.		15. DECEDENT'S ED (Specify only highest gra- Elementary/Secondary (0-12)		18a. DECEDENT'S (Give kind of v life. Do NOT us Teache	vork done during i e retired.)	TION most of working		kino of Busi		
ed by the hos build be detach	BE	17. FATHER'S NAME (First, Middle, Last) Harry Messnick  19a. INFORMANT'S NAME (Type/Print)		1			a Ja	cobow	itz	
ay be retained page 5 should be notified	٩	Susan Segal	200	903 L	ambert		e, S	ilver	Spri	ing,Md. 2090
Page 6 ma al director, p ner must	73	20a. METNOD OF DISPOSITION XX Burlal 2 Cremation 3 Re 4 Donation 5 Other (Specify)		etery, cremelos of o	**Cemet	ery	4-23	Que	ens,	New York
rs after death, Page 6 may be n by the funeral director, page removal.		Kiga D.	William	75	Fall	s Churc	h, V	a. 22	046	
d within 24 hours after impletely filled in by th I, cremation, or remove event, the medical	CERTIFICATION	23. PART I. Énter the disesses, or ehock, or heart feilure IMMEDIATE CAUSE (Final disesse or condition resulting in death)	a. SEP	ech line.		node of dyling, suc	ch es cerd	fiec or respire	etory errest	Approximata interval Between Onset and Deeth
in certificate be execute ending physician and confidence prior to burian or other traumatic		Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST	C	CONSEQUENCE OF	η:	E				to dap
by and	MEDICAL (	PART II. Other significant condition	PY FAIL	ut not resulting i	n the underlyi	ng ceuse given in	Part i.	24a. WAS AN A PERFORM 1 TYES 2	IED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
IVECTOR The law requires the conficate has been signed the State Dept. of Health or Item 23 shows an	SICIAN: I	DID TOBACCO USE CON' 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		F DEATH YE			N 🔲			
I PHYSICIAN	SYHAN	1 YES 2 MO  27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28a. OATE OF INJURY (Month, Day, Year)	26b. TIM	4 Nursing Ho E OF 28c. If	NJURY AT YORK?		(Specify)	JURY OCCUR	EO
OR ATTENDING DIRECTION AND Nouns Plant Nem 28 ft	ETBOR	3 Suicide 8 Could not be datarmined	28- DI ACE OF IN HIDY	— At home, farm, s	treet, fectory, off	len	281. LOCA City (	ATION (Street and or Town, State)	d Number or F	Rural Route Number,
# 25 F	COMPL		SICIAN: To the beat of my knowl							iuse(a) and manner as stated.
TO THE FUNERA TO THE FUNERA DE filed within 7 IMPORTANT: I	TO BE	29h. SIGNATURE AND TITLE OF CERTIFI	hem ho	)•		29c. LICENSE NUI				GNEO (Month, Day, Year) PIL 21, 1995
N		30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type,	By #	-401, R	oct	velle	MO	20852
,		APR 2 8 1995	STATE OF STA	N. WHE						

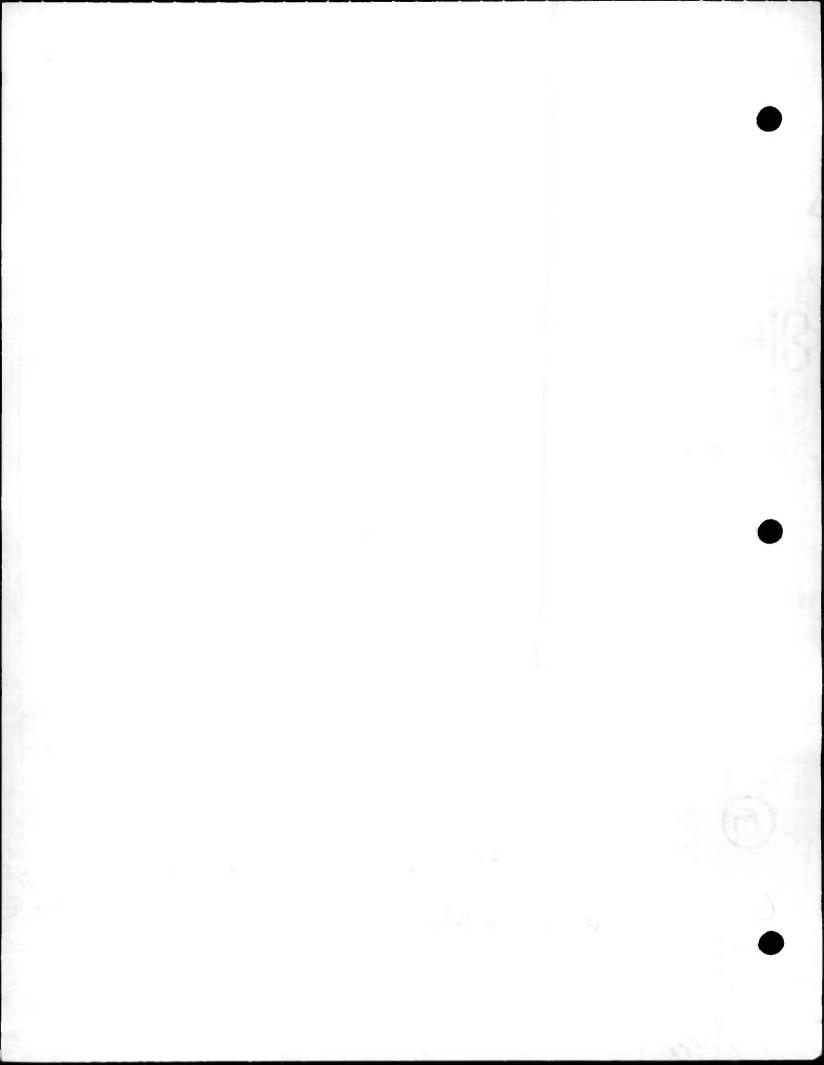


BALTIMORE, MARYLAND 21215-0020

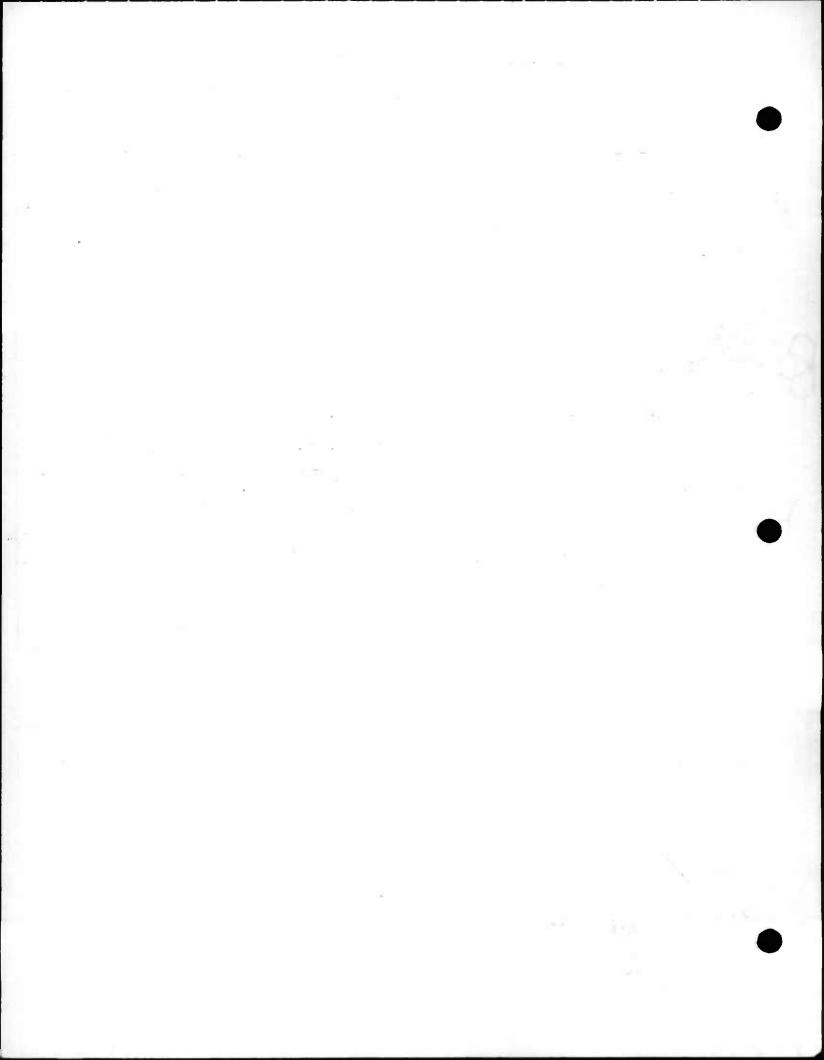
DIVISION OF VITAL RECORDS, P.O. BOX 68760

0300-01313 0110-1110-111-111	death. Page 6 may be retained by the hospital or attending physician.	e funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1.9.3 should	The state of the s	Control and the Control and th
	TO THE MEMORITY OF A MEMORING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	10 THE REMEMALE RECORD AND THE THIS certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1.9.3 security	be and any in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	the boundary of the second of the second sec

	1. DECEDENT'S NAME (First, Middle, Last)	TED							MONTH	OF OEATH	AY	YEAR	3. TIME OF DEATH
	JOHN CAR								1135.5	4/8/19	95		4:06 p
	4. SOCIAL SECURITY NUMBER 579-09-3771	5. SEX 1 [X] M 2 [] F	8. AGE (In yr	rs. lest birthday) YRS.	MONTHS 1	YEAR DAYS	HOURS	MIN.	(Month	Dey, Year) /29/19	200	8. BIRTH Country	PLACE (State or Foreign VA.
	9e. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY, T	OWN OF	LOCATI	ON OF OE		/ 49/1:		NTY OF D	
СТОЯ	SINIA HOSPITAL				ВА	LTI	MORE					LTO.	
EG	RESIDENCE OF DECEDENT  10e. STATE 10b. COUNTY	TTY 10c. CITY, TOWN OR LOCATION 10d. I									10d. INSIDE CITY		
DIRE	MD BAL	TO. CITY			BALTI								LIMITS?
ERAL	10e. STREET AND NUMBER						ZIP COD				10g. CIT	IZEN OF W	HAT COUNTRY?
Ä	2408 E. FEDERAL			_		2	1213	}			Ü	S.A	•
FUN	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS OECEDEN FORCES? 1	T EVER IN U.S	ARMED NO	13. W	S OECE	NDENT C	OF HISPAN	IIC ORIGIN	? (Specify Yes	or No-	14. RACE Black	- American Indian, White, etc.
ВУ	3 Widowed 4 Divorced	IF YES, GIVE V	MAR OR DATES	3				Specify		ioun, orday		-	ÄCK
ETED	15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)	.16	Give kind of	work done du	UPATION	N t of workin	ng	16b.	KIND OF BU	SINESS/IN		
PLE	Elementary/Secondary (0-12)	College (1-4 or 5	+)	UNKN						UNKNO	OWN		
COMPL	17. FATHER'S NAME (First, Middle, Last)						18. MOT	HER'S NAI	ME (First. N	liddle, Meiden		_	
ш	REV. JOHN CARTER								E CA				
TO B	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS (	Street and	d Number	or Rural R	loute Numb	er, City or Tow	n, State, Zij	Code)	
	WILMA A. MOORE 2408 E. FEDERAL ST. BALTO. MD 21213												
	20a. METHOD OF DISPOSITION  V Buriet 2 Cremetion 3 Removal from State  4 Donetion 5 Other (Specify)  A Donetion 5 Other (Specify)  DATE 20c. LOCATION - cremetary, cr									wn, State			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY												
	ESTEP BROTHERS FUNERAL HOME P.A.										-		
	23. PART I. Enter the blasses, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest,									Approximate			
	23. PART I. caref the gysesses, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Finel									interval Between			
	disease or condition resulting in deeth)	CEREB	RAL VA	SCULAR	ACCI	DEN'	Г						1 DAY
- 1	resulting in death)	DUE TO	(OR AS A CO	NSEQUENCE O	F):								
No.	Sequentielly list conditions,	·		INTEST		BLE	ED						1 DAY
Ĕ	If any, leading to immediate cause. Enter UNDERLYING			NSEOUENCE O	F):								
임	CAUSE (Disease or injury that initiated events	•	RATION	NSEQUENCE OF	FI-								1 DAY
ERTIFICATION	resulting in deeth) LAST		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,								
2	PART ii. Other significent conditions	contributing to	deeth but n	ot resuiting	in the unde	rivlac	COURS (	alvac in I	Part i	24a, WAS AN	ALIMORON	1 241	MATERIAL ALLEMAN AND AND AND AND AND AND AND AND AND A
1	HYPERTENSIO					arynig	50050	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		PERFOR	MED?	240.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC/									-	1 TYES 2	X NO		OF DEATH?
N: M	DID TOBACCO USE CONTR	IBUTE TO CA	USE OF D	EATH YE	S   NO	D C	UNC	ERTAIN					1 YES 2 NO
PHYSICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. F	PLACE OF DEAT		y one)							
YSI	1 TYES 2 XNO	1 X Inpatient 2	ER/Outpetier	N 3 □ DOA	OTHER: 4   Nursin	g Home	5 🗆 Re	sidence (	6 🗆 Other	(Specify)			
	27. MANNER OF DEATH  1 Natural 5 Pending	28e. DATE OF (Month, D		28b. TIM INJ	URY	WOR	K?		28d. DES	CRIBE HOW II	NJURY OC	CURED	
B	2 Accident Investigation	28a PLACE O	FINHIRY A	It home form			S 2	NO	201 1 2 2 2				
딢	3 Suicide 8 Could not be determined 28. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)							oute Number,					
Ž.	29e. CERTIFIER (Check only) CERTIFYING PHYSIC	IAN: To the best of	my knowleda	, death occurre	d at the time	, data =	nd place	and due	to the carr	a(a) and man	Dec en et-	ad	
COMPLE	2 MEDICAL EXAMINER	On the besie of e.	ramination and	Not investigatio	n, in my opin	ilon, des	ith occur	ed at the t	lime, data i	ind place, an	d due to th	a cause(s)	end manner as stated.

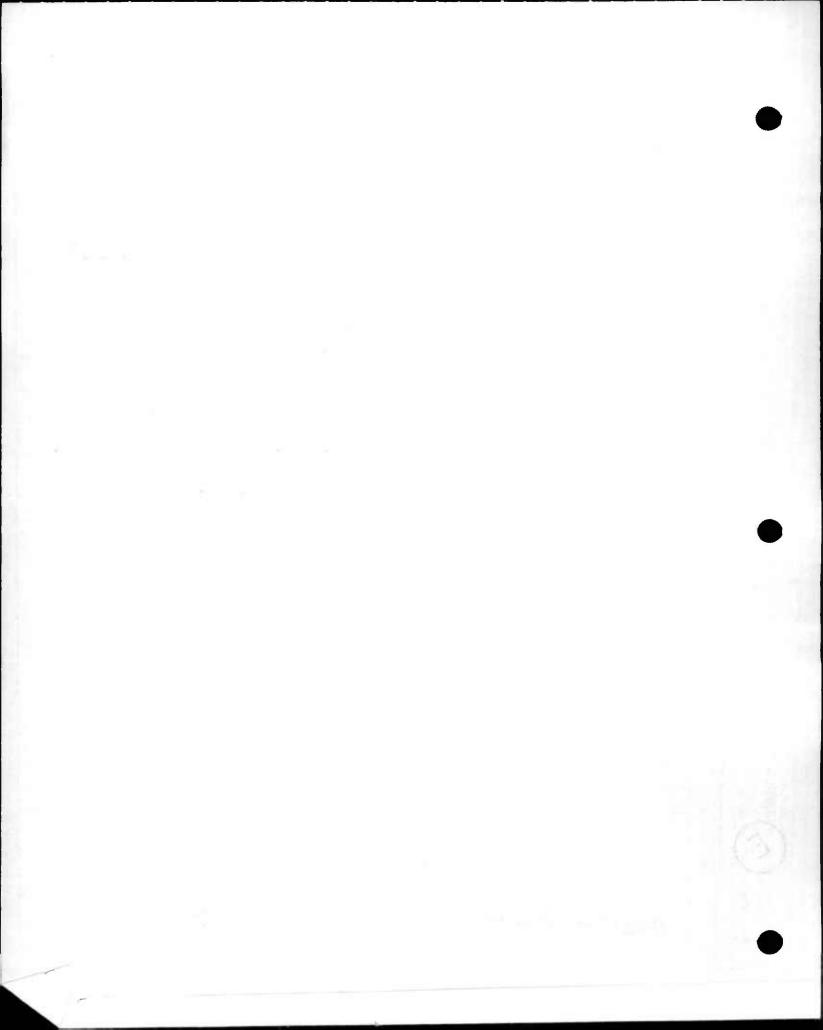


		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM	MENT OF I	HEALTH AND	MENTA	L HYGIEN				
	9	1. DECEDENT'S NAME (First, Middle, Last) Ruth	Marie		PER		MONT	OF DEATN	AY Y	EAR 3.	TIME OF DEATH	
		4. SOCIAL SECURITY NUMBER						11 24,	1995	5	:40 am.	
should		233~38~9079 9s. FACILITY NAME (If not institution, give st	1 □ M 2 Ø F 77	YRS.	NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Juli	th, Day, Ybar)	18	Country) Iirg.	ACE (State or Foreign	
1. 2, 3 sho	стоя	Franklin Square				Sville	DEATN		Balti		county	
Pages	DIRE	10e. STATE 10b. COUNTY Maryland		10c. CITY, T	OWN OR LOCA	Baltime	ore	City			d. INSIDE CITY LIMITS?  KXYES 2 \( \square\) NO	
in. ansit permit.	VERAL	1933 West Pratt.	Street		10	I. ZIP COOE	1223				States	
215-0020 attending physician. pe as he burta-fransit	BY FUN	11. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, OIVE WAR OR DA	2 NO	If yes, sp	ENDENT OF HISPA ecify Cuban, Maxic 2 X NO Speci	en, Puerio	N? (Specify Yes Rican, atc.)		BACE -	American Indian, Inlia, atc. White	
E ha		15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed)  College (1-4 or 5+)	18a. OECEDENT'S USI (Give kind of work life, Do NOT use re	done during mo		161	. KINO OF BU	SINESS/INDUS	TRY		
e My	弱	Unknown		Self	Employ	1ed		Nov	veltu			
	S	17. FATNER'S NAME (First, Middle, Last)				18. MOTNER'S NA			100			
MARYL retained by 5 should be notified at	BE	UNKNOWN  190. INFORMANT'S NAME (Type/Print)		400 404 400 40		Un Ri	nown					
MAR e retained 5 5 should notified	5	Mr. Arthur L. Dre	лаол.			Suite 5					202	
ORE, 6 may be ctor, page		20a, METHOD OF DISPOSITION 1 ABurial 2 Cremation 3 Remo	20h	PLACEANDDATEGE	EPOSITION /A/s	me of	0.07	20- 10	CATION ON		Dant-	
MORI age 6 may director, p		4 Donation 5 Other (Specify)		etery, cremetory or other 2adowridge	Mem.	Pk. 4/20	6/95	Dor	isey. N	laryl	Cand	
BALTIMORE, MARYL after death. Page 6 may be retained by by the funeral director, page 5 should be moval.		· ( hal or	V. Fred		7922	DADDRESS OF FI L-Ruck Fi Wise At	unera 10.	l Home Dundak	e of Du	ındal 212	ck, Inc.	
hin 24 hours tely filled in t mation, or red t, the med		23. PART 1. Enter the diseases, or cashock, or heart felture. I IMMEDIATE CAUSE (Finel disease or condition resulting in death)	omplications that could list only one couse of each	the deeth. Do not ech line.	enter the mo	de of dying, suc	ch ee cen	dlec or reepi	ratory arrest	,	Approximate Interval Between Onset and Dasti	
secuted within and completely oburial, crematic event, the			·	CONSEQUENCE OF):	1							
OX 68 e be execute sician and c nior to buria traumatic	ON	Sequentially liet conditions,  Infected Decubitus ulcers  Due To (OR AS A CONSEQUENCE OF):									l week	
BOX icate be physician ne prior t	CAT	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury										
P.O. ath certification at Hygier or oth	CERTIFICATION	that initiated events resulting in death) LAST	OUE TO (OR AS A	CONSEQUENCE OF):								
RDS, F nat the death by the atter and Mental	CALC	PART II. Other algolificent conditions	contributing to deeth be	at not resulting in t	he underlying	cause given in	Part I.	24a. WAS AN			RE AUTOPSY FINDINGS	
E # 0 # >	MEDIC							PERFOR		CO	MPLETION OF CAUSE DEATH?	
C 5 8 5 8	Σ	DID TOBACCO USE CONTR	BUTE TO CAUSE O	F DEATH YES		LINICEDTAL	N D			1 (	YES 2 NO	
OF VITAL INTROCEMENT OF STATE OF WITH THE STATE OF STATE	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE OF DEATH (		UNCERIAI						
VIII	YSIC	1 TYES 2 NO	HOSPITAL: 1XXinpatient 2 ER/Outp		THER:  Nursing Nom	e 5 🗆 Residence	8 🗆 Othe	er (Specify)				
	NI NI	27. MANNER OF DEATN  1 🔀 Naturel 5 🗌 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	WO	RK?	28d. DE	CRIBE HOW I	NJURY OCCUR	ED		
NOING IN After Is mar	BY	2 Accident Investigation	28a. PLACE OF INJURY	— Al home, ferm, etres		ES 2 NO	281 1.00	ATION /Street	and Number or F	Pural Bout	Mumber	
DIVISION OF VI- DR ATTENDING PHYSICIAN: DIRECTOR: After this certifica hours after death with the Siz Item 28 is marked, or It	ETED	4 Nomicide detarmined	building, etc. (Speci	(fy)			City	or Town, State)	ino rumber or r	oraz riousi	rumusi,	
D TO THE HOSPITAL D TO THE FUNERAL DI be filed within 72 ho IMPORTANT: If 116	COMPLET		IAN: To the best of my knowler On the basis of examination							use(s) an	d manner se stated.	
THE HI THE FL filled wi	HE (	29b. SIGNATURE AND TITLE OF CERTIFIED	2			29c. LICENSE NUI			29d. DATE SI	1 . 1	onth, Day, Year)	
6 6 3 ₹	5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	TN /ITEM 27 /3ma 04-	e)	RD 1767			<b>4</b>	24/	95	
1		S. Dyson, M.D. 90	000 Franklin	Square Dr		altimore	e, MD	21237				
, /		APR 2 8 1995	JULY OF WHOM	or Revolate								

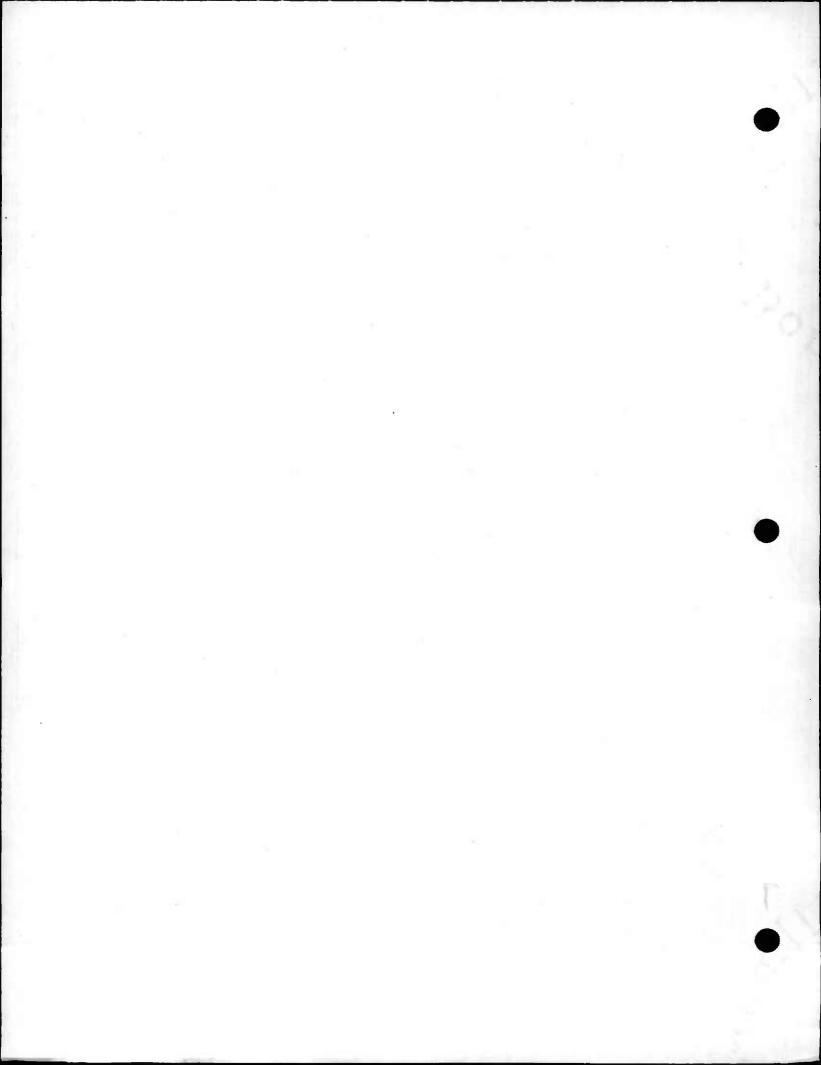


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	IR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours af	EDAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the first health with the State Dent of Health and Mental Hodison prior to hursal comparion or sense.
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	red	o e
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		1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIF	RTMENT OF I	HEALTH AND DEATH	MENTAL HYGIE REG. N			
			ovensky				2. DATE OF GEATH APTIL 2	4°,1995	3. TIME OF DEATH 3:22P M	
P		4. SOCIAL SECURITY NUMBER 383-38-3293	1 🛣 M 2 🗆 F	78 YRS.	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country) Michigan	
2, 3 should	OR	9a. FACILITY NAME (If not institution, give standard Hospit RESIDENCE OF DECEDENT			Bethe	OR LOCATION OF D		9c. COUNTY	of OEATH	
ages 1,	DIRECTOR	10e. STATE 10b. COUNTY			Y, TOWN OR LOCA	TION		THOTIC	10d. INSIDE CITY	
prysidari. burial-transit permit. Pages 1,		Maryland Mont  100. STREET AND NUMBER	gomery	Ве	ethesda	1. ZIP CODE		10e CITIZE	LIMITS?  1 YES 2 NO  N OF WHAT COUNTRY?	
fransit p	FUNERAL	13 Darby Court	12. WAS DECEDENT EVER	mulia sana		20817		U	J.S.A.	
se as the burial-tran	BY	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 XNO	If yes, sp	CENDENT OF HISPAL Hecity Cuban, Mexica 2 NO Specific	NIC ORIGIN? (Specify ) an, Puarto Rican, etc.) fy:	fes or No— 14	RACE — American Indian, Black, White, etc. Specify: White	
for u	COMPLETED	15. DECEDENT'S EQUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed)  College (1-4 or 5+)	18e. DECEDENT'S (Give kind of life. Do NOT u  Profes	usiness/indus ation	TRY				
uid be detached	BE CO	17. FATHER'S NAME (First, Middle, Lest) Joseph Covensky	nsky Cecelia Afsine							
page 5 should be notified		19a. INFORMANT'S NAME (Type/Print) Helen Covensky  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Darby Court, Bethesda, Md. 20817								
the funeral director, payal.  al examiner must b		20e. METHOD OF DISPOSITION  1 N Burlel 2 Cremetion 3 Remo 4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LIC	ovel from State ce	b. PLACE AND DATE imetery, crematory or o Lng Dav	ther place) Ld Mem. 22. NAME AI IVES	Gdn.  ND ADDRESS OF FA	4-26 Fa	al Hom	urch, Va.	
useur certificate or executes writin 24 not attending physician and completely filled ential Hygiene prior to burial, cremation, or iry, or other traumatic event, the m	CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF		47001	THY		Onset and Death Ismedinte  5 years	
ed by the h and Me	MEDICAL C	PART II. Other significant conditions		but not resulting	in the underlying	g ceuee given in	Part I. 24a. WAS A PERF(	N AUTOPSY DRMED? 2 X NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO	
has bee Dept. o	IAN:	DID TOBACCO USE CONTR	IBUTE TO CAUSE O	OF DEATH YE		UNCERTAIN	N 🗆			
the State or item	PHYSICIAN:	EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH	HOSPITAL: 1   Inpetient 2   ER/Out	tpetlent 3 DOA	OTHER: 4  Nursing Hom		6 Other (Specify)			
After this death with	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	28s. OATE OF INJURY (Month, Day, Year)	28b. TIM INJ	URY WO	VRY AT RK? YES 2 NO	26d. DESCRIBE HOW	INJURY OCCUR	ED	
CTOR: A after di 28 is	ED	3 Suicide 8 Could not be detarmined	28e. PLACE OF INJUR building, etc. (Spe	Y — At home, farm, i	street, factory, office	•	28f. LOCATION (Stree City or Town, State	and Number or i	Surel Floute Number,	
12	COMPLET		CIAN: To the best of my known: On the basis of examination						suse(s) and manner as stated.	
MPORTANE	TO BE C	290. SUGNATURE AND TITLE OF CERTIFIER	his m	1		29c. LICENSE NUN		29d. DATE SI	GNED (Montyl. Day, Year)	
5	Ė	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type,	Print) Che V	y Chh	SP, MO	208	2/3	
- 1	1	APK & 0 1333 0~		**	/					



		FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	HEALTH AND	MENTA	L HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Las	it)				2. DATE	OF DEATH	NY Y	3	TIME OF DEATN
		Charles A.	Dunston				Apri	1 25	5 199		1:15 p
pjn		217 64 5012  90. FACILITY NAME (If not institution, give	1 / M 2 □ F 4]	In yrs. lest birthday) YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	6/1	OF BIRTN h, Day, Year) 9/53		MD.	
2. 3 should	OB	ST. AGNES HOS	PITAL		BALTI	OR LOCATION OF D	EATH		9c. COUNTY BALTO		
es 1.	DIRECTOR	RESIDENCE OF DECEDENT  10e. STATE 10b. COUR		10c. CITY	TOWN OR LOCAL	TION					Od. INSIDE CITY
permit. Pages		MD . BAT	LTO, CITY	В	ALTIMOR					1	LIMITS?  YES 2 NO
	FUNERAL	3708 W. FRANI	ZITN CT		10	f. ZIP CODE					AT COUNTRY?
020 physician. burial-transit	NS I	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC	21229 CENOENT OF NISPA	NIC ORIGI	17 (Specify Yaa	USA or No-	RACE -	- American Indian,
21215-0020 al or attending physician for use as the burial-trai	B	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 // YES	2 _NO		ecity Cuban, Mexic 24 NO Speci		Rican, etc.)	AF	Specify:	MERICAN
2121 al or atter for use a	ETED	15. DECEDENT'S Et (Specify only highest gra	DUCATION ide completed)	18a. DECEDENT'S L	ork done during me	ON ost of working	168	KIND OF BUS	SINESS/INDUS		
D 2 spital o	PE	Elementary/Secondary (0-12)	College (1-4 or 5+) N/A	OPERATI		1	ומ	EPT. O	F PIIRT	TC W	IOBK
AND the hospital detached for once.	COMPL	17. FATNER'S NAME (First, Middle, Last)	N/A	OFERALL	ON IEC.	18. MOTNER'S NA		_		IC N	OKK
d by the	BE 0		JNSTON			WILHE	LMIN	A DUI	NSTON		
retained 15 should notified	0	19a. INFORMANT'S NAME (Type/Print) DELORES DUNST(	) N.T.			and Number or Rural					<u>.</u>
May be on page 5 st be n		DELORES DUNST(		.PLACE AND DATE OF		ICHAEL L					
BALTIMORE, MARYLAND after death. Page 6 may be retained by the hospit by the funeral director, page 5 should be detached moval. ical examiner must be notified at once.		1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from Stata	RRISON F	ÖREST 5	/2/95	DAT		NGS MI		
ALTIMO death. Page 6 tuneral directo		21. SIGNATURE OF FARRERAL SERVICE	LICENSEE &		22, NAME A	NO ADDRESS OF FA					1110 .
SAL r deatl ne fun al.		leal C	(Teles	7		P BROTHE EUTAW P					
hours aff ed in by or remo		23. PART I. Enter the diseases, of snock, or haert failure IMMEDIATE CAUSE (Final	r complications that caused a. List only ona cause on a	the death. Do no	ot enter tha mo	oda of dying, suc	ch ss can	diac or respi	ratory errest		Approximate Intervel Between Onset and Death
tery Tage		disease or condition resulting in death)	a. Upper GI OUE TO (OR AS A	bleeding	3						days
P 2 2 3		_	OUE TO (OR AS A Cirrhosi:		:						years
5 6	ION	Sequentielly list conditions, if any, leading to immediate	b	CONSEQUENCE OF)	:						years
EOX cate be e thysician e prior to	ICA	CAUSE (Disease or Injury	a Alcohol	abuse							years
certifi ding p tygien	CERTIFICATION	thet initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF)							
(DS, P. the death cy the attending Mental Hy Injury, or			d								
that the that the that the that the and the and the that the the that the the the the the the the the the th	EDICAL	PART II. Other algoriticant conditi	ons contributing to death be	ut not resulting in	the underlying	g ceuse given in	Part I.	24a. WAS AN PERFOR 1X YES 2	MED?	AL CI	ERE AUTOPSY FINDINGS MILABLE PRIDR TO OMPLETION OF CAUSE F DEATN?
H = - 0	ME										YES 2 NO
law las t Dept	AN:	DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL	CONTRIBUTE TO	CAUSE OF			-				
- = = = = =	PHYSICIAN:	EXAMINER?	HOSPITAL:		OTHER:	LACE OF DEATH (CI		- 11			
OF VI PHYSICIAN: this certifica with the St rked, or It	ЭНХ	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c, INJ	IURY AT	_	CRIBE NOW II	NJURY OCCUR	ED	
NG PHYS fiter this eath with	ВУ Б	1 Netural 5 Pending 2 Accident Investigation		INJU	44	YES 2 NO					
TTENDI TTOR: A after of 28 is	ETED I	3 Suicide 6 Could not b 4 Nomicide determined	28s. PLACE OF INJURY building, atc. (Spec	— At home, ferm, st	reat, factory, offic	a	28f. LOC City	ATION (Street a or Town, State)	nd Number or	Rumi Rou	te Number,
L OR A L DIREC hours	PLE	29a. CERTIFIER (Check only	SICIAN: To the best of my knowl	edga, daath occurred	i at the time, date	and place, and due	to the car	use(a) and man	iner se stated.		
THE SE	À		NER: On the besis of examination							euse(s) e	nd manner as stated.
A 28	Ē.	29b. SIGNATURE AND TITLE OF CERTIF	IER //			29c. LICENSE NU	MBER		29d. DATE SI	GNED (M	onth, Day, Year)
P	0	30. NAME AND ADDRESS OF PERSON V	WHO COMPLETED CALLES OF ST	ATM (ITEM AT CT	Online)	D30802			► Ap	ril	26, 1995
						Coto- 1	116	D-1	24,517	M. 1	04000
,		Dr. Jean Colandre 31. DATE FILED (Month, Day, Near) APR 2 8 1995	32 BEGISTRAR'S FORM	aluspica Auguspica	T - 900	oaton A	ve	Balti	more,	Md.	21229
		APK Z 8 1995	James warmen again	V							



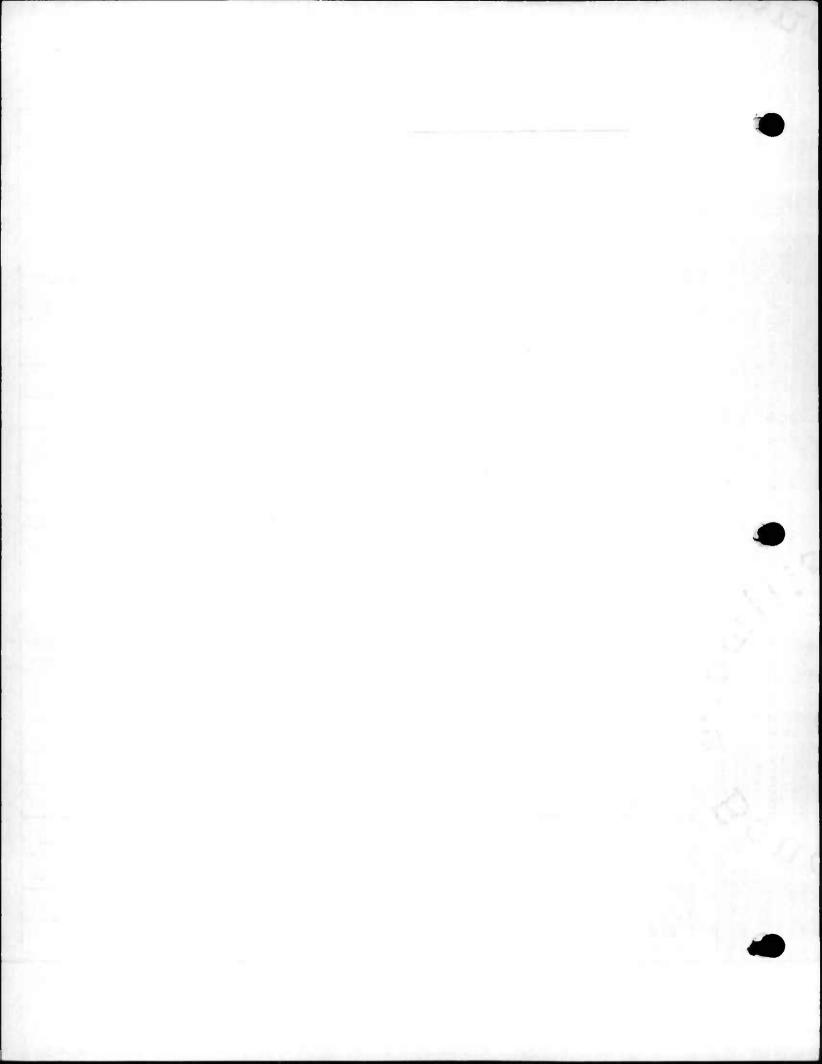
BALTIMORE, MARYLAND 21215-0020	ON STREETHEN DESCRIPTION OF THE CO. STREETHER THE CO. STREETHER THE CO. ST. CO
D. BOX 68760,	Specificant has seen and state.
FAL RECORDS, P.O. BOX 6876	The face has been been the same about
DIVISION OF VITAL RE	OD ATTENDISC DESCRIPTION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within transming after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	Item#1. G-film 7	22 per F.	H 4/28/	95 P.	C						
	FOR 1 - STATE REGISTRAR	STATE OF N	ARYLAND /	DEPAR				TENTAL			
	1. DECEDENT'S NAME (First, Middle, Last)	Agnes H	elen D			P DEAL	<u> </u>	2. DATE C			3. TIME OF DEATN
1 8	AGNES		mmen		31100			API	2// 5		YEAR 14:55 M
1	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. les		IF UNDER 1 YEA			7. DATE O	F BIRTN		8. BIRTHPLACE (State or Foreign
1	112-10-6257	1 🗆 M 2 💢 F	81	YRS.	MONTHS DAY	'S HOURS	MIN.	12-	Day, Year) [4-19]	13	New York
-	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY, TOW	N OR LOCATIO	ON OF DEA	ATN		9c. COUN	TY OF OEATH
[ P	719 Maiden Choice	Lane Apt	501		Cato	nsvill	е			Ba	ltimore
DIRECTOR	10e. STATE 10b. COUNT			10c. CIT	Y, TOWN OR LO	CATION					10d, INSIDE CITY LIMITS?
=	Maryland Balti	more		Cat	tonsvil	le					LIMITS?
AL	10e. STREET AND NUMBER			1 00.		10f. ZIP CODE				10g. CITIZ	ZEN OF WHAT COUNTRY?
FUNERAL	719 Maiden Choice	Lane Ap	t. 501			2122	28			U	.S.A.
E	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT FORCES? 1	T EVER IN U.S. AF	RMED NO		DECENDENT OF				or No-	14. RACE — American Indian, Black, White, etc.
B	3 X Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES			ES 2 X NO			, , ,		Specify: White
8	15. DECEDENT'S ED		16a. DE	CEOENT'S	USUAL OCCUP	ATION		166.1	CINO OF BUS	NESS/INDI	
1	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4 or 5 +	) (G	ive kind of v Do NOT us	vork done during se retired.)	most of working	9				
Į Į		5+		eache	er					Schoo	1
COMPLET	17. FATHER'S NAME (First, Middle, Last)					4		IE (First, Mi	ddle, Maiden	Surname)	
BE	Edward		Brow				len				ussell
2	19a. INFORMANT'S NAME (Type/Print)				ADDRESS (Stre						
	Mrs. Patricia Joh	nson			Park Av	- 10	nnas				030
	1 Donation 5 Other (Specify)	noval from State			of DISPOSITION		E /				City or Town, State
5	3t. bomis cemetery 3/4/35 Middle Village, N. F.										
	Paul L. Hartsock, Jr. Leonard J. Ruck, Inc. 5305 Harford Rd.										
	23. PART I. Enter the diseases, or	complication that	onused the de	anth Da a	Lec	onard L	. Ku	ICK, I	nc.	5305	Hartord Rd.
	shock, or heart failure.	List only one caus	se on each line	).	or enter the	mode of dyn	ng, such	aa caro	ac or respi	ratory arre	Interval Between
	IMMEDIATE CAUSE (Final disease or condition	DAG	DCREA	TU	OA	2000	)				Onset and Death
	resulting in death)					10 CC					MONTHS
'	DUE TO (OR AS A CONSEQUENCE OF):										
Z	Sequentially list conditions	b									
ATION	Sequentially list conditions, if any, leading to immediate	b. OUE TO	OR AS A CONSE	QUENCE OF	F):						
FICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	с									
RTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	с	OR AS A CONSE								
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	c. DUE TO (	OR AS A CONSE	QUENCE OF	n;						
Ū	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	c. DUE TO (	OR AS A CONSE	QUENCE OF	n;	ying cause g	iven in P	Part I,	24a, WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMULABLE PRIOR TO
Ū	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	c. DUE TO (	OR AS A CONSE	QUENCE OF	n;	/ing cause g	iven in P			MED?	
Ū	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	c. DUE TO (	OR AS A CONSE	QUENCE OF	n;	ring cause g	iven in P		PERFOR	MED?	MAILABLE PRIOR TO COMPLETION OF CAUSE
Ū	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other algnificant conditions and the conditions in the conditions are conditions and the cause of the ca	c. DUE TO (	OR AS A CONSE	QUENCE OF	n the underly			_	PERFOR	MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?
Ū	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other algnificant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?	d	OR AS A CONSEC	QUENCE OF	in the underly 26	. PLACE OF DE	EATH (Chec	ck only one)	PERFOR	☐ NQ	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?  1 YES 2 N NO
Ū	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other algnificant conditions and the conditions are supported by the conditions are supported by the cause of the cau	d	death but not r	QUENCE OF	on the underly  26  OTHER: 4 □ Nursing h  E OF	. PLACE OF DE	ATH (Chec	ck only one	PERFOR	MED?	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 1 NO
PHYSICIAN: MEDICAL C	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other algnificant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO  27. MANNER OF DEATN  1  Natural 5  Pending	d	death but not r	QUENCE OF	OTHER: 4   Nursing   E OF   28c.	. PLACE OF DE	EATH (Chec	ck only one	PERFOR	MED?	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 1 NO
BY PHYSICIAN: MEDICAL C	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other algnificant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATN  1 Hatural 5 Pending Investigation  3 Suicide 8 Could not be	d	death but not r  ER/Outpatient 3 INJURY INJURY INJURY — At ho	POURNCE OF POUR POUR POUR POUR POUR POUR POUR POUR	OTHER: 4   Nursing   E OF   28c. URY M 1 [	. PLACE OF DE tome 5 Real Real Real Real Real Real Real Real	EATH (Chec sidence 8	ck only one; Other 28d. DESC	PERFOR  1 YES 2  (Specify)  RIBE HOW II	MED?	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 1 NO
ED BY PHYSICIAN: MEDICAL C	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other algnificant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO  27. MANNER OF DEATN  1  Accident Investigation	d	death but not r	POURNCE OF PROBLEM OF THE PROBLEM OF	OTHER: 4   Nursing   E OF   28c. URY M 1 [	. PLACE OF DE tome 5 Real Real Real Real Real Real Real Real	EATH (Chec sidence 8	ck only one; Other 28d. DESC	PERFOR	MED?	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 - YES 2 1 Ng
ED BY PHYSICIAN: MEDICAL C	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other algnificant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO  27. MANNER OF DEATN  1  Astural 5  Pending Investigation  2  Accident   Investigation   Pending Investigation    3  Suicide   Could not be determined   Centifying PNYS	d	death but not a  ER/Outpatient 3 INJURY IN, War)  FINJURY — At ho	QUENCE OF PROBLEM STATE OF THE	OTHER: 4   Nursing h E OF 28c. URY M t [	PLACE OF DE tome 5 Resilinjuny AT WORK? YES 2 Title	ATH (Chec	281. LOCAL	PERFOR  1 YES 2  (Specify)  RIBE HOW II  TION (Street a Town, Stete)	MED?	AMNILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 1 NO  2 CALL OF HEST DENCE URED
ED BY PHYSICIAN: MEDICAL C	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other algnificant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO  27. MANNER OF OEATN  1  Astural 5  Pending Investigation  3  Suicide 8  Could not be determined  29e. CERTIFIER (Check only)	DUE TO ( d	death but not in the state of t	QUENCE OF resulting I	OTHER: 4   Nursing   E OF	PLACE OF DE forme 5 Rest Rest Rest Rest Rest Rest Rest Rest	NO end due le	28d. DESC	PERFOR  1   YES 2  (Specify)   RIBE HOW II  FION (Street or Town, Stete)	MED?  NO  NO  NO  NO  NO  NO  NO  NO  NO  N	AMNILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 1 NO  2 CALL OF HEST DENCE URED
COMPLETED BY PHYSICIAN: MEDICAL C	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other algnificant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO  27. MANNER OF OEATN  1  Astural 5  Pending Investigation  3  Suicide 8  Could not be determined  29e. CERTIFIER (Check only)	d. DUE TO d	death but not in the state of t	QUENCE OF resulting I	OTHER: 4   Nursing   E OF	PLACE OF DE forme 5 Res INJURY AT WORK? YES 2 Milities and place, n, death occurs	NO end due le	28d. DESC City or	PERFOR  1   YES 2  (Specify)   RIBE HOW II  FION (Street or Town, Stete)	MED?  INO  NO  NO  NO  NO  NO  NO  NO  NO  N	AMNILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 1 NO  LECAL AT HS; Dence URED  OF Rural Route Number,
BE COMPLETED BY PHYSICIAN: MEDICAL C	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other algnificant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	d	death but not a  ER/Outpatient 3 INJURY IN, War)  F INJURY — At hosts. (Specify)  my knowledge, de	QUENCE OF PROBLEM OF THE PROBLEM OF	25 OTHER: 4   Nursing N E OF 28c. URY M 1 [ street, factory, o	PLACE OF DE forme 5 Res INJURY AT WORK? YES 2 Milities and place, n, death occurs	NO end due it in the time at the time.	28d. DESC City or	PERFOR  1   YES 2  (Specify)   RIBE HOW II  FION (Street or Town, Stete)	MED?  INO  NO  NO  NO  NO  NO  NO  NO  NO  N	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?  1 YES 2 NO VERNOR OF PRIVATE
COMPLETED BY PHYSICIAN: MEDICAL C	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other algnificant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO  27. MANNER OF OEATN 1  Intural 5  Pending Investigation 1  Investigation 1  Investigation 2	DUE TO ( d	death but not is  ER/Outpatient 3 INJURY INJURY — At hoste. (Specify)  my knowledge, de amination and/or	QUENCE OF resulting I	26 OTHER: 4   Nursing h E OF URY M   1   Rirest, factory, o	PLACE OF DE lorne 5 Rest NUMBER AT WORK?  YES 2 Office State and place, n, death occure 29c. LICE!	NO end due le dat lihe til	281. LOCAL City or o the cause ima, date e	PERFOR  1 YES 2  (Specify)  RIBE HOW II  FION (Street or Town, Stete)  e(e) end mennd place, en	MED?  NO  NO  NO  NO  NO  NO  NO  NO  NO  N	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 D NO  CALL AT HES DEALER  URED  OF Rural Route Number,  Ad.  Cause(s) and manner as stated.  SHONED (Month, Day, Year)  Pull 27   1993
BE COMPLETED BY PHYSICIAN: MEDICAL C	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other algnificant condition  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	DUE TO ( d	death but not is  ER/Outpatient 3 INJURY INJURY — At hoste. (Specify)  my knowledge, de amination and/or	QUENCE OF resulting I	25 OTHER: 4   Nursing N E OF 28c. URY M 1 [ street, factory, o	PLACE OF DE lorne 5 Rest NUMBER AT WORK?  YES 2 Office State and place, n, death occure 29c. LICE!	NO end due le dat lihe til	281. LOCAL City or o the cause ima, date e	PERFOR  1   YES 2  (Specify)   RIBE HOW II  FION (Street or Town, Stete)	MED?  NO  NO  NO  NO  NO  NO  NO  NO  NO  N	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 D NO  CALL AT HES DEALER  URED  OF Rural Route Number,  Ad.  Cause(s) and manner as stated.  SHONED (Month, Day, Year)  Pull 27   1993



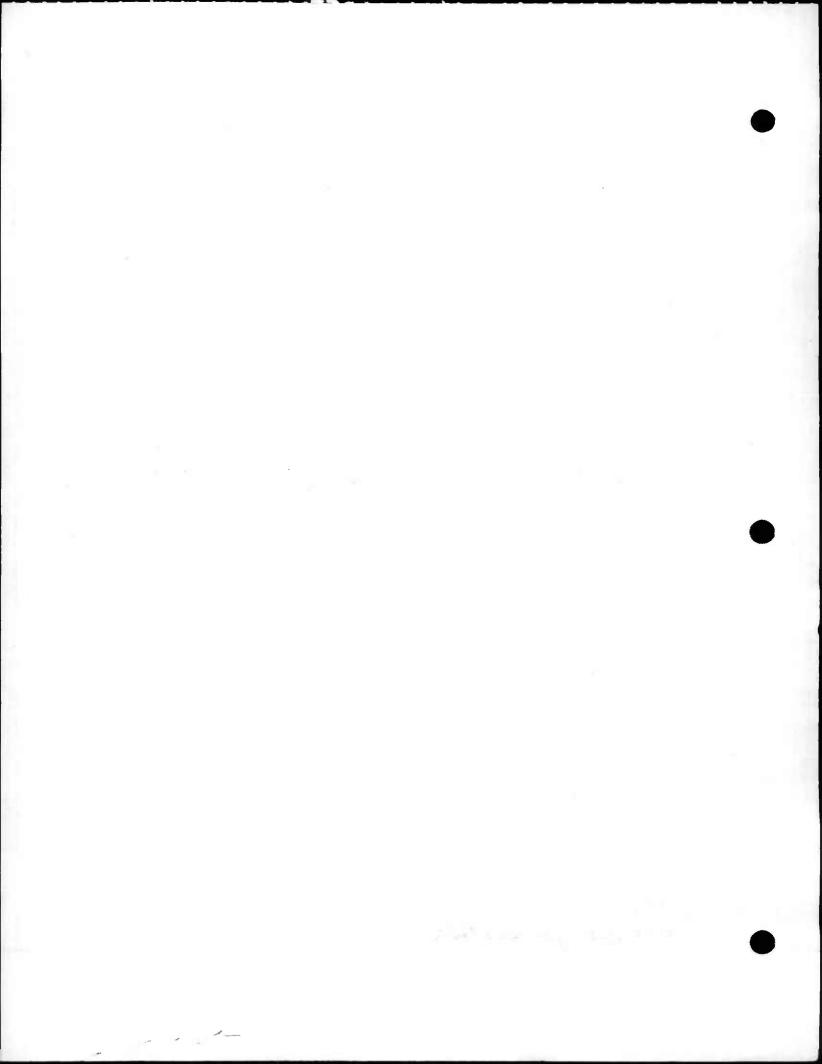
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within cours after death. Page 6 may be retained by the hospital or attending physician.

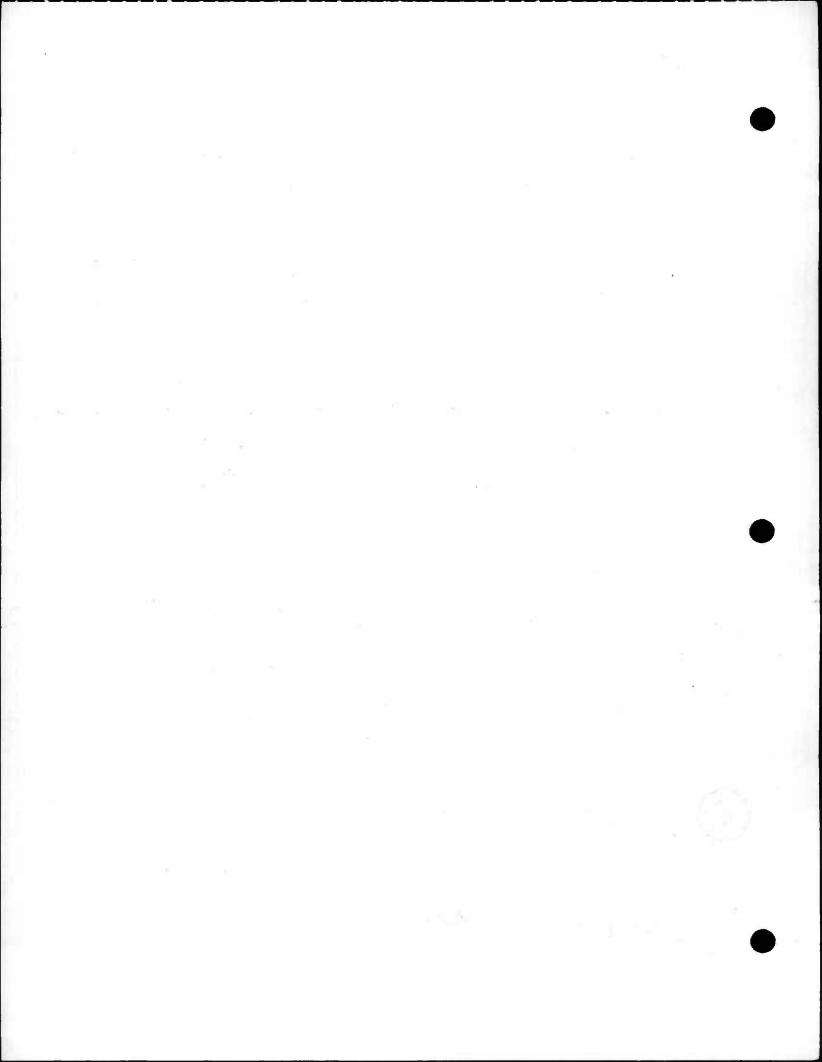
TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND		NT OF HEALTH AND	MENTAL HYGIEN		
	1. OECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH
	0	us Donley			April 23	, 1995	8:00 A. M
		5. SEX 6. AGE (In yrs. In	rst birthday) IF UI WONT	NDER 1 YEAR IF UNDER 24 HRS. HB DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	Coun	HPLACE (State or Foreign fry)
	9e. FACILITY NAME (If not institution, give stre		-	CITY, TOWN OR LOCATION OF	March 21,	910 Peni	
NO.		ourt		Baltimore	ZEATH		imore
رز	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY					30000	
DIRECTOR		timore	10c. CITY, 10V	n or location Baltimore			10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER			101. ZIP CODE		10a. CITIZEN OF	1 TES 2XXNO WHAT COUNTRY?
FUNERAL	4 Krisswood Cou	rt		2	1236	u.s.	Α.
FU	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT EVER IN U.S. AI FORCES? 1 X YES 2	RMED NO	13. WAS DECENDENT OF HISPA If yes, specify Cuban, Mexic	en, Puerto Rican, atc.)	or No — 14. RAC Blac	E — American Indian, ik, White, etc.
ΒY	3 🕅 Widowed 4 🗆 Divorced	IF YES, GIVE WAR OR DATES		1 TYES 2 NO Spec	ity:	Spec	"White
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of		ECEOENT'S USUA	L OCCUPATION	16b. KIND OF BUS	SINESS/INDUSTRY	
LET	Elementary/Secondary (0-12)	College (1-4 or 5+)		one during most of working od.)	Automob		
MP	8th grade 17. FATHER'S NAME (First, Middle, Lest)		Itility		Manufac		
ŭ	James Donley				M. Still		
TO BE	19a. INFORMANT'S NAME (Type/Print)			ESS (Street and Number or Rural	Route Number, City or Tow	n, State, Zip Code)	
F		son)		wood Ct., Ba	ltimore, MD	21236	
	20a METHOD OF OISPOSITION 1 ABuriel 2 Cremation 3 Remov	al from State 20b. PLACE cemetery, cr	ANO DATE OF DIS	position (Nome of Cem.		CATION — City or To	
	4 ☐ Donation 5 ☐ Other (Specify)  21. SIGNATURE OF FUNDINAL SERVICE LICE				4/26 Bal	umore, i	narykana
	· Milles (	Work		22. NAME AND ADDRESS OF F Schimuner Ful	neral Homes	, Inc.	0102/
	23. PART I. Enter the diseases, or co	mplications that ceused the d	eeth. Do not er	9705 Belair 1			
	shock, or heart fellure. Li IMMEDIATE CAUSE (Finel	et only one ceuse on eech line	e.	ner tha mode of dying, su	cii es cardiec or reepi	ratory arrest,	Approximate Interval Between Onset and Death
	disease or condition resulting in deeth)	Alterna leaster	e lands	menta D	which .		65 km
		DUE TO (OR AS A CONSE					
NO N	Sequentially list conditions, b.	DUE TO (OR AS A CONSE	OHENCE OF				
CAT	If any, laeding to immediate ceuse. Enter UNDERLYING						
E	CAUSE (Disease or injury that initieted events resulting in death) LAST	OUE TO (OR AS A CONSE	OUENCE OF):				
CERTIFICATION	d.						
CAL	PART II. Other significant conditions	contributing to death but not	reculting in the	underlying cause givan in	Part I. 24a. WAS AN PERFOR		. WERE AUTOPSY FINDINGS
50	Pro Centraren	La Dochet			1 🗆 YES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH?
MEDI	DID TODA GGO HGT GOVERN						1  YE\$ 2 NO
PHYSICIAN:	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL		CE OF DEATH (Ch		и□]		
SIC	EXAMINER?	HOSPITAL:	OTH	IER: Nursing Home 5  Rasidenca	9 C Other (Consists)		
¥.	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJURY AT WORK?	28d. DESCRIBE HOW II	JURY OCCUREO	
BY	1 Natural 5 Pending 2 Accident Investigation	(morall, day, loar)	N	1 YES 2 NO			
	3 Suicide S Could not be detarmined	28e. PLACE OF INJURY — At he building, atc. (Specify)	ome, larm, street,	lactory, office	281. LOCATION (Street a City or Town, Stete)	nd Number or Rural I	Route Number,
COMPLETED	29a. CERTIFIER				177		
MP	(Check only CERTIFYING PHYSICI	AN: To the best of my knowledge, do On the basis of examination and/or					
	29b. SIGNAPORE AND PITTED CERCURA			29c. LICENSE NU			
BE C	1168611	a mid.		D/85		29d. DATE SIGNED	(Month, Day, Year)
임	30. NAME AND ADDRESS OF PERSON WHO					1/064/	/3
			600 6	SLER DR	TOWSON	30 2	1204
	APR 2 8 1995 Julia	32. REGISTRAR'S SIGNATURE				-	
	HI R & 0 1333 7	The second					



	1 - STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTA	L HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last	Eisner				MONT	of OEATH	1 9:	EAR	TIME OF DEATH  8 10 P M
	4. SOCIAL SECURITY NUMBER 800-02-2563	1 □ M 2X F 9	O YRS.	ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Aug	of BIRTH	904 C	Country)	ACE (State or Foreign ecticut
TOR	9a. FACILITY NAME (If not institution, give Levindale Nurs:			Baltir	NOTE	EATH		9c. COUNTY	OF DEAT	Ä
DIRECTOR	100. STATE 106. COUN Maryland	NA		imore	ION					d. INSIDE CITY LIMITS?  XYES 2 \( \text{NO} \)
FUNERAL	10e. STREET AND NUMBER 2500 West Belv	vedere Aven	ue, #511		21215				S.A.	T COUNTRY?
BY	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 _ YES IF YES, GIVE WAR OR DO	2 ANO		ENOENT OF HISPAI city Cuban, Mexica 2 NO Specifi	in, Puerto		e or No- 14	Black, W Specify:	American Indien, thite, atc. White
COMPLETED	15. DECEDENT'S EO (Specify only highest grace   Elamentary/Secondery (0-12)		16a. DECEDENT'S US (Give kind of wo life. Do NOT use Homemak	k done during mos retired.)		168	OWN	siness/indus		WI TOO
BE CO	17. FATHER'S NAME (First, Middle, Last)  Samuel Spector	^			18. MOTHER'S NA Bessie					
10	190. INFORMANT'S NAME (Type/Print) Allen J. Eisne	er	3407 M	DORESS (Street ar	nd Number or Rural Hill Rd	Route Num	ber City or Tow Balti	m, State, Zip Co	Md.	. 21215
	20e_METHOO OF OISPOSITION 1/3 / Burlel 2 Cremation 3 Rei 4 Donation 5 Other (Specify)	movel from State	PLACE AND DATE OF PLACE OF PLACE OF PLACE PLACE OF PLACE OF PLACE PLACE OF PLACE OF PLACE OF PLACE PLACE OF PLACE OF PLA	DISPOSITION (Nat L'ubav	vitz Ce	m 4 24	20c. LO	oseda		Maryland
	21. SIGNATURE OF FUNERAL SERVICE L	indow		Ives- Falls	Pearso Churc	n Fi	Va. 2	2046		
AL CERTIFICATION	23. PART I. Entar the diseases, or ahock, or heart feilure IMMEDIATE CAUSE (Final disease or condition resulting in desth)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST	a. Probable  DUE TO (OR AS A  DUE TO (OR AS A	sch ilna.							Approximate Interval Batween Onset and Dasth 3 O MINUTE
님	PART II. Other algnificant condition	ena contributing to death b	ut not resulting in	the underlying	causa given in	Part I.	24a. WAS AN PERFOR	RMED?	CO OF	RE AUTOPSY FINDINGS MILABLE PRIOR TO MPLETION OF CAUSE DEATH?  YES 2 NO
PHYSICIAN: MEDIC	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH	(Check only one)	UNCERTAI	N 🗆				
D BY PHYSICI	1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending Investigation 3 Suicida 8 Could not be	1 □ Inpetient 2 □ ER/Outp  26e. DATE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY	28b. TIME (INJUE)	DF 28c. INJU WOR M 1 VI		28d. DES	SCRIBE HOW I	NJURY OCCUR		e Number,
O BE COMPLET	2 MEDICAL EXAMIN 29b. SIONATURE AND TITLE OF CERTIFIE	> sthere w	TENDIN PHYSIC:	G AN	ath occured at the	to the cau	use(e) and mer	d due to the c		onth, Day, Year)
	30. NAME AND ADDRESS OF PERSON WILL STATE OF THE STATE OF		TH (ITEM 27) (Type, PI	im) SE	ENDE J HJI	IZAL IZAL	กิกอา	SE W	0 5	21215



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BALTIMORE, MARYLAND 21215-002	acuted within 24 hours after death, Page 6 may be retained by the hospital or attending physical
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		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEP/ CERTI	ARTMENT OF	F HEALTH AND OF DEATH	MENTAL	HYGIENE REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Lest)  A LACH T  4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	2A81	ER	SR.	2. DATE O	11 22			
pin		251-22-1423  9a. FACILITY NAME (If not institution, give st	1×M2□F 71	'In yrs. last birthda YR\$	MONTHS DAY	75 HOURS MIN.	7. DATE OF (Month) 8/7/	1923	SOL	RTHPLACE (State or Foreign intry) JTH CAROLINA	
1, 2, 3 should	TOR	ST. AGNES HOSPIT				IMORE	DEATH	9c.	CITY		
Pages	DIRECTOR	10a. STATE 10b. COUNTY MARYLAND CITY			BALTIMOR					10d, INSIDE CITY LIMITS? 1 📉 YES 2 🗌 NO	
n. ansit permit.	UNERAL	100, STREET AND NUMBER 838 N. AUGUSTA AV	Έ,			101. ZIP CODE 21229		10g.	USA	F WHAT COUNTRY?	
215-0020 attending physician. se as the burial-transit	BY F	11. MARITAL STATUS 1 Never Married 2 Married 3 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 ∑ YES IF YES, GIVE WAR OR OF 1943 - 1946	2 NO	If yes,	DECENDENT OF HISPA , apecify Cuban, Mexic YES 2 NO Speci	an, Puerto Ric	(Specify Yea or No sen, etc.)	fee or No— 14. RACE — American Indian, Black, White, etc.  Soacity:  ARF • AMERICAN		
5 6 J	LETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	CATION completed)  College (1-4 or 5 +)	(Give kind	I'S USUAL OCCUP of work done during use retired.)		16b. K	IND OF BUSINESS	3/INDUSTRY	,	
the hospital detached to once.	COMPL	12 17. FATHER'S NAME (First, Middle, Last)	0	BAKEI	R HELPER			BAKER _Y -		ECTIONARY IN	
MAHYL retained by the 5 should be continued at continued	BE	JAMES FRASIER  19a. INFORMANT'S NAME (Type/Print)		19b. MAILI	NO ADORESS (Stre	P OLL		FRASIER	e Zin Code)		
be be	2	QUEEN A. FRASIE	206	838		STA AVE,	BALTI		RYLAN		
Page 6 ma al director, ner must		1 N Buriel 2 Cremation 3 Ramo 4 Donalion 5 Other (Specify)	com	SARRISOI	Y FOREST	CEMETERY	4/28/9	OWING	S MII	LL, MARYLAND	
death. funera		Flyd 1	4. Oste		ESTE 1300	E AND ADDRESS OF FA LP BROTHER DEUTAW PL	S FUNI	BALTIMOR	RE. MI		
y filed in by the titlon, or removal the medical		23. PART I. Enter the chaeses, or o shock, or heart failura. L IMMEDIATE CAUSE (Final disease or condition	liet only one couse on a	ech line.		mode of dying, suc	ch as cardis	c or reapiratory	arrest,	Approximata interval Between Onset and Deat	
executed within and completel o burial, crema		resulting in death)	DUE TO (OR AS A							z week	
be executed and control burian and control burian and control burian aurmatic	CATION	Sequentially list conditions, if any, leading to immediate cause, Enter UNDERLYING	DUE TO (OR AS A		P Neum	LONIEN				Zweek	
death certificate attending physic ental Hygiene pri	CERTIFICA	CAUSE (Disease or Injury that initiated evente resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE	OF);				-		
that the ed by the h and M	MEDICAL C	PART II. Other algnificent conditions PYO State care Hypertensia	inoma cit	/h me	eterstas	is		4s. WAS AN AUTOF PERFORMED?		4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO	
PHYSICIAN: The law requires this certificate has been significate has been significate has been significate of Health of Healt	SICIAN:	DID TOBACCO USE CONTR			YES NO		ИП				
CIAN: T ertificate the State	IYSIC		HOSPITAL:			fome 5 - Residence					
this o	ву Рну	27. MANNER OF DEATH  Natural 5 Pending 2 Accident Investigation	26a. DATE OF INJURY (Month, Day, Year)		NJURY	INJURY AT WORK?  YES 2 NO	26d. DESC	RIBE HOW INJURY	OCCUREO		
	8	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, etc. (Speci	— At home, farm	n, street, factory, o	ffice	28f, LOCATI City or	ION (Street and Nu Town, State)	nber or Rura	i Floute Number,	
OSPITA OR MERA DIR MT. II hou	COMPLET		IAN: To the best of my knowler. On the bests of examination							r(a) and manner as stated,	
TO THE HOSPIT TO THE FUNER DE filed within 7	TO BE (	0-11	Jarjour	MO.				29d.	A PY	(Month, Day, Year) -22-95	
6		SAMIH JARJOUR	Stagnes	HOSPITA	Per Print) 900	cation A'	NE B	ALTIME	RE, I	U-22-95	
W		"APR 2"8 1995 Jul	AND PARTIES.	TAME							

Item # 9b.10c Film # G 722 4-28-95 N.A. Per Funeral Home FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH April SERENA **AGNES FILBERT** 26 1995 11;30 A. M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 217-12-3959 1 M 2 X F 74 16. 111. 1921 Jan permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR 5440 Princess Drive Baltimore Rossville Baltimore 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore Rossville Maryland Baltimore 1 YES 2 1 NO FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit in Mental Hygiene prior to burial, cremation, or removal. 5440 Princess Drive United States 21236 retained by the hospital or attending physician. 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yea, specify Cuban, Mexican, Puerto Rican, stc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married BY 1 YES 2 X NO Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INOUSTRY (Specify only highest grade College (1-4 or 5+) N/A Elementary/Secondary (0-12) 12 Homemaker N/A 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Joseph Longo F Mary Padovano BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 John A. Filbert Baltimore, Md. 21237 5440 Princess Drive hours after death. Page 6 may be pe 20a. METHOO OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State must 1 Donation 5 Other (Specify) Arlington National 5/2/95 Alexandria Virginia 21. SIGNATURE OF FUNERAL SERVICE LIGENSEE examiner 22. NAME AND ADDRESS OF FACILITY Milton J Knight Leonard J. Ruck Funeral Home, Inc. 5305 Harford Rd. Balto. Md. 21214 the medical 23. PART I. Enter the diseases, or complications that a ath. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximats shock, or haart fallura. Liet only one can Interval Between Onset and Death IMMEDIATE CAUSE (Fine) disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF event, traumatic CERTIFICATION Sequentially list conditions. QUE TO (OR AS A CONSEQUENCE OF)if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury or other DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS signed by the AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 YES 2 NO 1 | YES 2 | NO t. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO M PHYSICIAN: UNCERTAIN has be Dept. HOSPITAL OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINERT

1 YES 2 DIRECTOR: After this certificate he hours after death with the State Item 28 is marked, or Item HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. OEȘCRIBE HOW INJURY OCCURED Natural 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide ETED. 8 Could not be 4 Homicide datermined 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner ea stated. COMPL (Check only one) TO THE HOSPITAL
TO THE FUNERAL I
Be filed within 72 h
IMPORTANT: If II MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, data and placa, end due to the cause(a) end manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIED 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE 9

CAUSE OF DEATH (ITEM 27) (Type, Print)

Crossroads Dr. Owings Mills , Md.

21117

DHMH-16 Rev 1/89

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DIRECTOR: Afr hours after de-item 28 is n

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NG PHYSICIAN: IT	S CELL	eath with the State Dept. of Health and N		marked, or item 23 snows any injury, or other traumatic event, the medical examiner must be notitied at once
A PH	ier in	ath wi		narre

Item # 7 Film # q 722 4-28-95 N.A. Per Funeral home FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First Middle Leat) 2. DATE OF DEATH MONTH 3. TIME OF DEATH DAY 26, 1995 Margaret Elizabeth Feldman April 6:45 p.m. M 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) _IF UNDER 1 YEAR 7. DATE OF BIRTH 6-23-1916 8. BIRTHPLACE (State or Foreign Country) 1 M 2 F DAYS HOURS 78 Maryland Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 8714 Stockwell Road Parkville Baltimore RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Randallstown 1 YES ZXX NO FUNERAL 10e STREET AND NUMBER 101. ZIP CODE 10o. CITIZEN OF WHAT COUNTRY? 9712 Kerrigan Court 21133 United States WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 TNO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Maxican, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 2 XNO If yes, specify Cube
1 YES 2 KNO IF YES, GIVE WAR OR DATES 8 Specify: 3 Wildowed 4 Divorced Caucasian COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 166 KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) tary/Secondary (0-12) College (1-4 or 5 +) 12th Housewife Home 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Sumame) Plitt BE Etta Krusmann 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, ဥ Henry Feldman 5402 Eliots Oak Road Columbia, MD 21044 20a. METHOD OF DISPOSITION
1 ☐ Burlal 2 ☒ Cremetion 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Carroll Cremation, INC. 4/27/95 4 Donation 5 Other (Specify) Hampstead, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, INC. 8728 Liberty Rd Randallstown, MD 21133-4784 23. PART 1 Enter the diseases, of complications that caused the daeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart feiture. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Daeth diseese or condition days resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Atheroscherosis 45005 CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST PART ii. Other significant conditions contributing to death but not recuiting in the underlying ceuse given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 - YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES NO UNCERTAIN 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: OTHER:
4 \( \text{Nursing Home} \) 5 Residence 6 \( \text{Other} \) Other (Specify) 1 TES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 27. MANNER OF DEATH 28a, DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO 8 Accident Investigation 3 Sulcide 28s. PLACE OF INJURY — Al home, farm, street, lactory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29e. CERTIFIER 1) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, data and place, and due to the cause(a) and manner as stated.

MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER

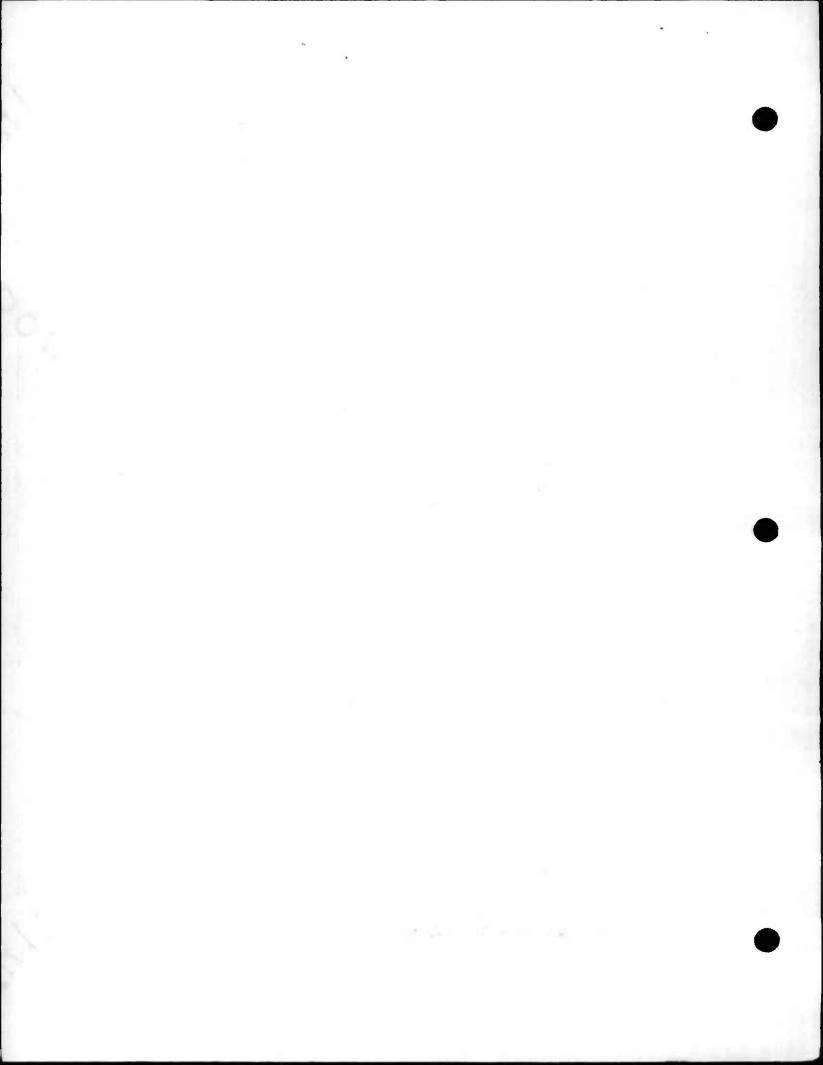
29d. DATE SIGNED (Month, Day, Year)

ALTIMORE- MARYLAND 21204

30. NAME AND ADDRESS, OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VORTH HARLES #405.

31. DATE FILED (Month, Day, Year) APR 2

		1 - STATE REGISTRAR				CERTIF					MENTAL	REG. NO.			
		1. DECEDENT'S NAME (First	, Middle, Last)	FEI	ME	R					2. DATE OF	DEATH DA	7 5	YEAR	3. TIME OF DEATH
29		4. SOCIAL SECURITY NUMBER 217-52-88	347	5. SEX 1	6. AGE (In yrs. 79		IF UNDER 1	YEAR DAYS	IF UNDER HOURS	24 HRS. MIN.	7. DATE OF (Month, I	Day, Year)	15   16 995	Country)	LACE (State or Foreign
3 should	E .	Saint Eliz					96. CITY, 1						9c. COUN	TY OF DE	ATH
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ing physician. the bunal-transit permit, Pages 1,	BY FUNE	11. MARITAL STATUS  1 Never Married 2 3 X Wildowed 4 Dive	Married	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 24	ARMED	H :	yes, spe	ENDENT C	212: OF HISPAN II, Maxica Specify	IC ORIGIN?	(Specify Yea an, etc.)	or No-	14. RACE -	S.A  — American Indian, White, atc.
r attending use as the		15. DEC	EDENT'S EDUC	CATION COMPOSITION	16a.	DECEDENT'S	USUAL OCC	UPATIC	DN		18b. K	IND OF BUS	I SINESS/INDU	JSTRY	White
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by the	BE CO	17. FATHER'S NAME (First, M Charles		h							ME (First, Mic			Z	4
be retained ge 5 should e notified	5	Margaret	,,	/illiams	5	196. MAILING 521	Ship:								21090
e 6 may rector, pa must b		20a. METHOD OF DISPOSIT XI XI Burial 2 Crematic 4 Donation 5 Other	on 3 🗆 Rame	oval from Stata	cemetery,	crematory or c	other plece)			, 199	DATE	20c. LO	Mary		n, Stata
		21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE	N		22. N/	AME AN	D ADDRES	SS OF FA	CILITY				
		()()	7	Dory	-4	, ·	150	01	E. Fo	rt Av	enue,	ens r Baltim	ore, M	arvla	Home, Inc nd 21230
within hours at mpletely filled in by cremation, or removent, the medical		23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one ceuse on each line.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Due TO (or As A Consequence ph:													
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TTENDING PHYSICIAN: The law requires that the death of CIDR: After this certificate has been signed by the attend after death with the State Dept. of Health and Mental Hy 28 is marked, or Item 23 shows any injury, or	ED BY PHYSICIAN: MEDICAL C	Cause, Enter UNDERLY CAUSE (Disease or Inju- that initiated eventa reculting in death) LAS  PART II. Other signification  DID TOBACC  25. WAS CASE REFERRED, T EXAMINER? 1 YES 2 MO  27. MANNER OF OEATH 1 Natural 5 2 Accident 3 Suicide 8	o USE	CONTRIBUT	deeth but no	SEOVENCE O	F DEATI	26, PL 1g Home 8c. INJI WO 1  Y	YES	NC EATH (Chi	8 Other (:	PERFOR  YES 2  /  Specify)	NED?	URED	MANLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH!
AL OR ATTENDING PHYSICIAN: The law requires that the death of AL DIRECTOR. After this certificate has been signed by the attend? I hours after death with the State Dept, of Health and Mental Hi Item 28 is marked, or Item 23 shows any injury, or	ED BY PHYSICIAN: MEDICAL C	Cause. Enter UNDERLY CAUSE (Disease or Injuted Intelleted events resulting in death) LAS  PART II. Other signification of the control of the	O USE O MEDICAL  Pending Investigation Could not be determined determined PHYSI	CONTRIBUTION OF MONTH,	deeth but not a control of the contr	SEOVENCE O	In the und  F DEATI  OTHER: SURVINITION M  street, factor	26. PL ng Home 8c. INJI WO 1  Y y, office	ZES	NC EATH (Chi	8 Other (: 28d. DCSCI	PERFOR  YES 2  Specify)  RIBE HOW III  ON (Street a fown, State)	NO NO NUMBER OCC	URED Or Rural Ro	WALLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH!  YES 2 NO
OR ATTENDING PHYSICIAN: The law requires that the death of DIRECTOR: After this certificate has been signed by the attend hours after death with the State Dept, of Health and Mental Hitem 28 is marked, or item 23 shows any injury, or	BY PHYSICIAN: MEDICAL C	Cause. Enter UNDERLY CAUSE (Disease or Injuted Intelleted events resulting in death) LAS  PART II. Other signification of the control of the	O USE O MEDICAL  Pending investigation Could not be determined  FIFYING PHYSI ICAL EXAMINE	CONTRIBUTION OF THE PROPERTY OF THE PARTY OF	deeth but not a control of the contr	SEOVENCE O	In the und  F DEATI  OTHER: SURVINITION M  street, factor	26. PL ng Home 8c. INJI WO 1  Y y, office	ACE OF D.  ACE OF D.  9 5 Re  10 Re	NC EATH (Chi	28t. LOCAT City or to the cause time, date ar	PERFOR  YES 2  Specify)  RIBE HOW III  ON (Street a fown, State)	NJURY OCC	URED  Or Rural Ro  d. cause(s)	MANLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH!



should

law requires that the death certificate be executed within HOSPITAL OR ATTENDING PHYSICIAN: The DIRECTOR: After this certification of the hours after death with the Item 28 FUNERAL within 72 h

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IMPORTANT: If

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ate has been signed	State Dept. of Health an	item 23 shows any in	

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. OATE OF OEATH 3. TIME OF CEATH FALK 23 1:55 AM M JOSEPH R. APRIL 1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign 1 M 2 D F DAYS HOURS SEPT. YRS. MARYLAND 579-14-4578 89 5 1905 96. CITY, TOWN OR LOCATION OF DEATH 9a. FACILITY NAME (If not institution, give street and number) 9c. COUNTY OF DEATH DIRECTOR JEWISH CONVALESCENT & NURSING HOME BALTIMORE BALTIMORE RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 10c. CITY. TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE MARYLAND N/A 1 X YES 2 NO FUNERAL 10s. STREET AND NUMBER 109. CITIZEN OF WHAT COUNTRY? 101. ZIP CODE 21215 209 USA 5715 PARK HEIGHTS AVE APT. 14. RACE — American Indian, Black, White, atc. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-FORCES? 1 YES 2 NO If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1X Naver Merried 2 Mars 1 TYES 2 NO Specify Specify: В 3 Widowed 4 Divorced WHITE COMPLETED 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high at of working Elementery/Secondary (0-12) **JOURNALISM** 12 SPORTS WRITER 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN SHIFRA RAPHAEL FALK BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 3402 OLD POST DRIVE BALTIMORE 21208 MRS. FRANCES REICHER 20e. METHOD OF DISPOSITION

1 Disposition 3 - Removal from State 20b. PLACE OF OISPOSITION (Name of cemetery, crematory or 20c. LOCATION - City or Town, State ANSHE EMUNAH (AITZ CHAIM) 4/24/95 BALTIMORE Donation 5 🖵 Other (Specify) 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS 21. SIGNATURE OF FUNERAL SERVICE LICENSES INC rua 6010 REISTERSTOWN ROAD BALTIMORE MD 21215 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such se cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between ARTERY Occlusion Onset and Death IMMEDIATE CAUSE (Final disease or condition MIN resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF): MIN CERTIFICATION Sequantielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS ENESCIBICE COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? 1 - YES 2 - NO ICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: PHYSI 1 TYES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 🙀 Nursing Home 5 🗆 Rasidenca 8 🗆 Other (Specify) 27. MANNER OF CEATH 28s. DATE DF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 XNatural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, lactory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide a 🗌 Could not be COMPLETED 4 Homicide 29a. CERTIFIER

//Check only

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the lime, data and place, and due to the cause(s) and menner as stated. 296. SIGNATUM AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 95

5740

BALTIMORE

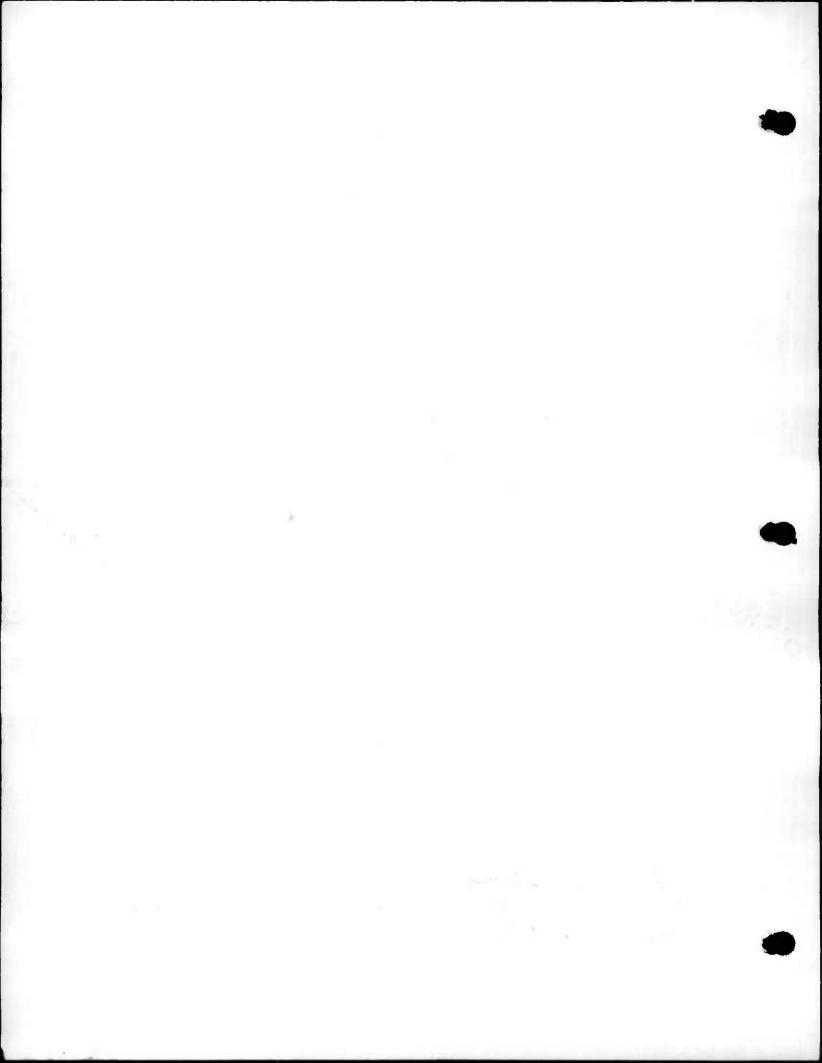
6210 PARK HEIGHTS AVENUE

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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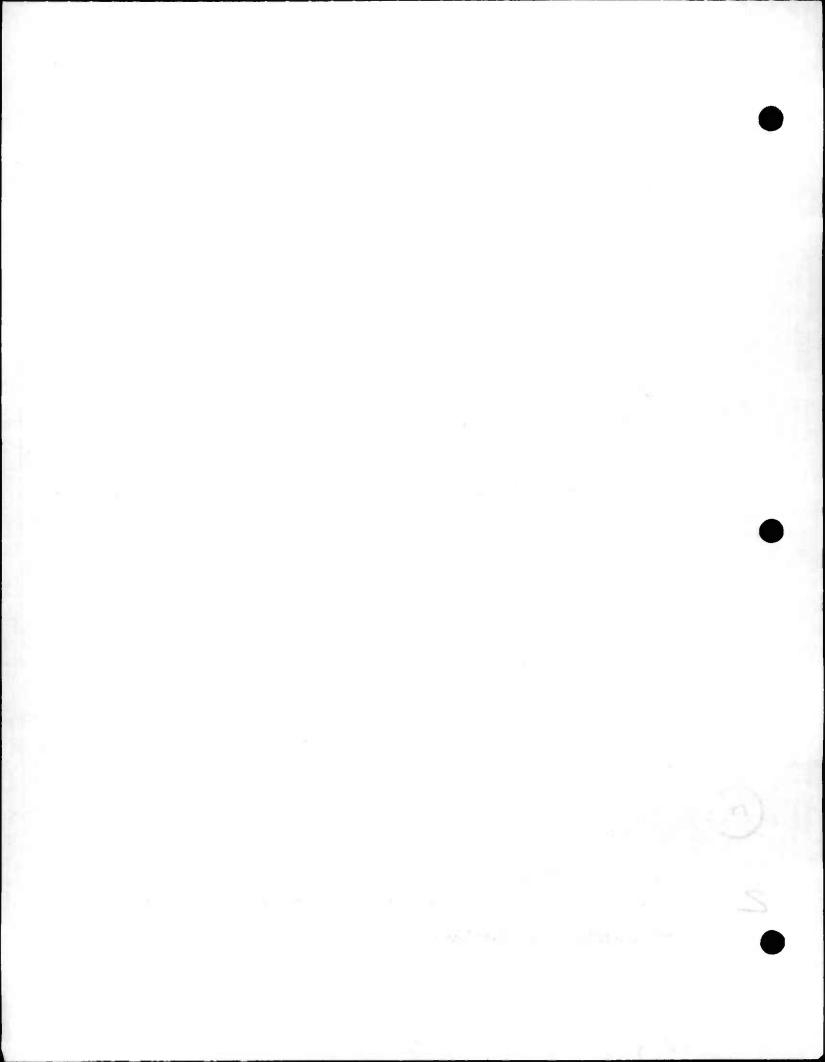
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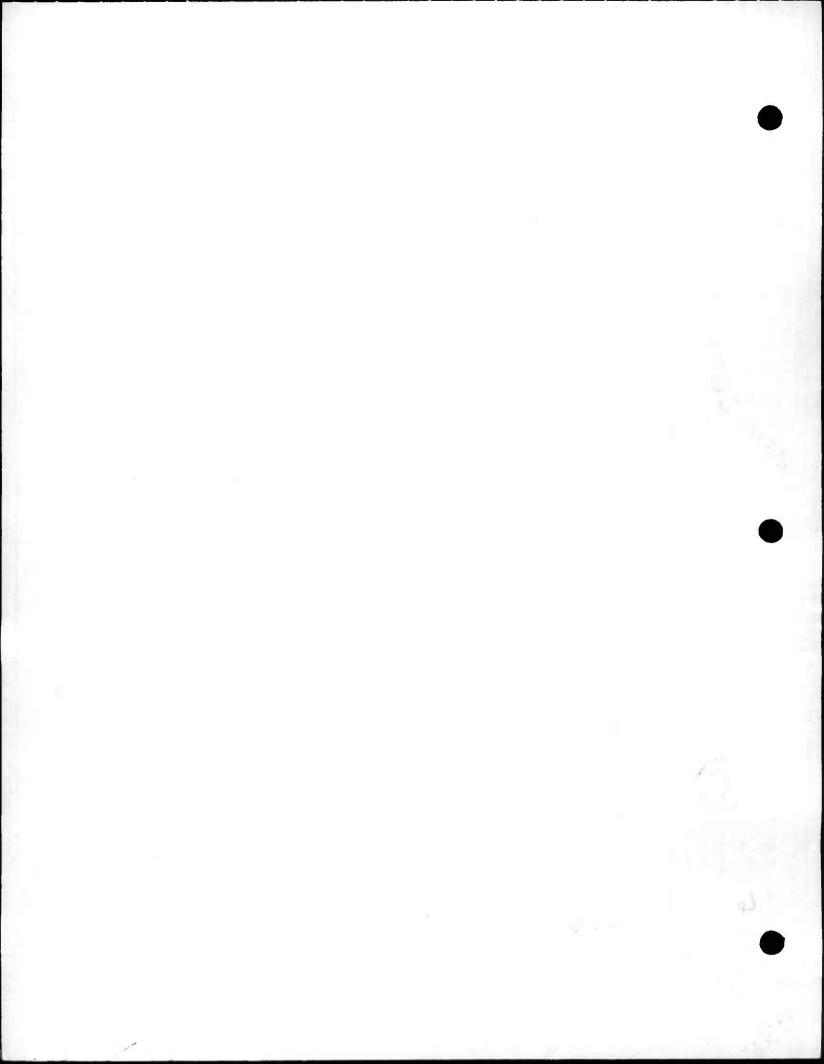
DIME PHYSICAN. The law requires that the death certificate he executed within an investment after the following physician.

After this certificate has been signed by the attending physician and competitive fleet in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be attached on them 23 shows any injury, or other transmatic event, the medical examiner must be notified at once. QUDING PHYSICIAN: The law requires that the death certificate be executed within TO THE HUSPITA OFF TO THE FUNE AL DISCITO THE MITTER 72 HUST SIT IMPORTANT (IT MAIN 28

	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPA CERTII	RTMENT (	F HEALTH	AND M	ENTAL HYGIEN REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Lest, TOLLIE	NELSON			GILL		2. DATE OF DEATH	ž	9 ^{YEAR}	3. TIME OF DEATH  1:55 P.M
	4. SOCIAL SECURITY NUMBER		E (In yrs. lest birthday)	# UNDER 1 Y		_	7. DATE OF BIRTH			PLACE (State or Foreign
	216-03-0578	1 🔯 M 2 🗆 F	95 YRS.		AYS HOURS	MIN.	(Month, Day, Year) APr.1-19	000	Country	v)
1	9a. FACILITY NAME (If not institution, give	street and number)	<u> </u>	9b. CITY, TO	WN OR LOCATIO			9c. COUNTY OF DEATH		
8	1143 WICOMICO	STREET		BAL	CIMORE	CIT	Y	N A		
DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNT	TY	10c, CI	TY, TOWN OR	OCATION					10d, INSIDE CITY
H	Md. N	/A		D-1+	imore					LIMITS?
	10s. STREET AND NUMBER			Dalt	101. ZIP CODE			10g. CITI	ZEN OF W	HAT COUNTRY?
FUNERAL	1143 WIcomico			2123	30		U.	S.A.		
1 2	11. MARITAL STATUS 1 Never Married 2 Married						ORIGIN? (Specify Yes Puerto Rican, etc.)	or No-	14. RACE	- American Indian, White, atc.
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OF	DATES		YES XXNO		r dello ricell, etc.)		Specif	ly:
	15. DECEDENT'S ED	UCATION	16a. DECEDENT	S USUAL OCCI	PATION		16b, KIND OF BUS	NESS/IND	Whi	te
COMPLETED	(Specify only highest gred Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT	work done duri	ng most of working	7				
, <u> </u>	12 yrs		Pai	nter			Unic	n		
8	17. FATHER'S NAME (First, Middle, Last)				18. MOTH	ER'S NAM	E (First, Middle, Maiden	Sumame)		
BE	John Tollie G:	111					Gibson			
ဍ	190. INFORMANT'S NAME (Type/Print) CHerie Grange)	r	19b. MAJLIN	G ADDRESS (S	reet and Number of	or Rural Ro	ute Number City or Town	n, State, Zip	Code)	21158
			2 1 U	_		IIWC		CATION —		
	20e. METHOD OF DISPOSITION  1 Burlet 2 Cremation 3 Rer  4 Donation 5 Other (Specify)		cemetery, crematory or CHesape	other placel		Y 11				
	21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE	CIICBUPE	22. NA	ME AND ADDRESS	S OF FACI	LITY			21222
	1 VA (	)					on Funer			, Inc.
	23. PART I. Enter the diseases, or	complications that cause	sed the death. Do	not enter the	4 W111	OW such	Spring R	d . I	Balt	O Md Approximate
	shock, or heart failure. IMMEDIATE CAUSE (Final	. List only one cause on	each line.		-					Interval Between Onset and Death
	disease or condition	Arten	School	to (	molin )	ru C.	la Des	uln		
		DUE TO (OR A	A CONSEQUENCE	OF):						
NO.	Sequentially list conditions,	b	A CONSEQUENCE O	100						
PA TA	if any, leading to immediate cause. Enter UNDERLYING									i
Ĕ	CAUSE (Disease or Injury that initiated events	DUE TO (OR A	A CONSEQUENCE O	W):						
CERTIFICATION	resulting in death) LAST	4								
	PART II. Other significant condition	ns contributing to death	but not resulting	in the unde	tying cause gi	iven in Pr	ert L. 24s. WAS AN	AUTOPSY	240.	WERE AUTOPSY FINDINGS
NCAL	Chimic Obsta	within Pul		Dire			PERFOR		1000	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MED				0 0,				7",		OF DEATH?
ż	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH Y	ES 🗆 NO	☐ UNCE	RTAIN	1 list	oto		A.M. 0.0.0. (2.00.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.0.
CA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	OTHER:	onej		-		- Ai	
PHYSICIAN:	1 X YES 2 □ NO 27. MANNER OF DEATH	1 Inpetient 2 II ER/O		4 C Nursing			Other (Specify)			
	Matterial 5 Pending	(Month, Day, Year		JURY	WORK?	73.01 T	red. DESCRIBE HOW IN	WURY OCC	CURED	
BY	2 Accident Investigation 3 Suicide 5 Could not be	28s. PLACE OF INJU	RY At home, farm.		Office		M. LOCATION (Street a	net Number	to Breat Br	note Months
品	4 Homicide determined	building, etc. (%)	pecify)			- 1	City or Town, State)	nu municipi	or murar m	AUM NUMBER
두	29s. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the best of my kn	owledge, death occur	red at the time	date and place.	and due to	the causeis) and man			
COMPLET	(100) XXMEDICAL EXAMIN	ER: On the besis of examina	tion and/or investigati	on, in my apin	on, death occured	d at the tic	ne, date and place, and	due to the	e cause(s)	and manner as stated.
BE C	296. SIGNATURE AND TITLE OF CERTIFIE	m _/			29s. LICEN	ISE NUMB	en I	29d. DATE	SIGNED	(Moreth, Day, Wear)
TO B	Theodor .	U. Tre	No		O.C.	M.E	.			24,1995
15		HO COMPLETED CAUSE OF			4	-	144			- 4 01000
	31. DATE FILED (Month, Day, Your)	UIFING		enn S	treet,	, ва	rtimore,	Ma	ryla	ind 21201
	APR 2 8 1995	ale Dayoler Re	and the same							
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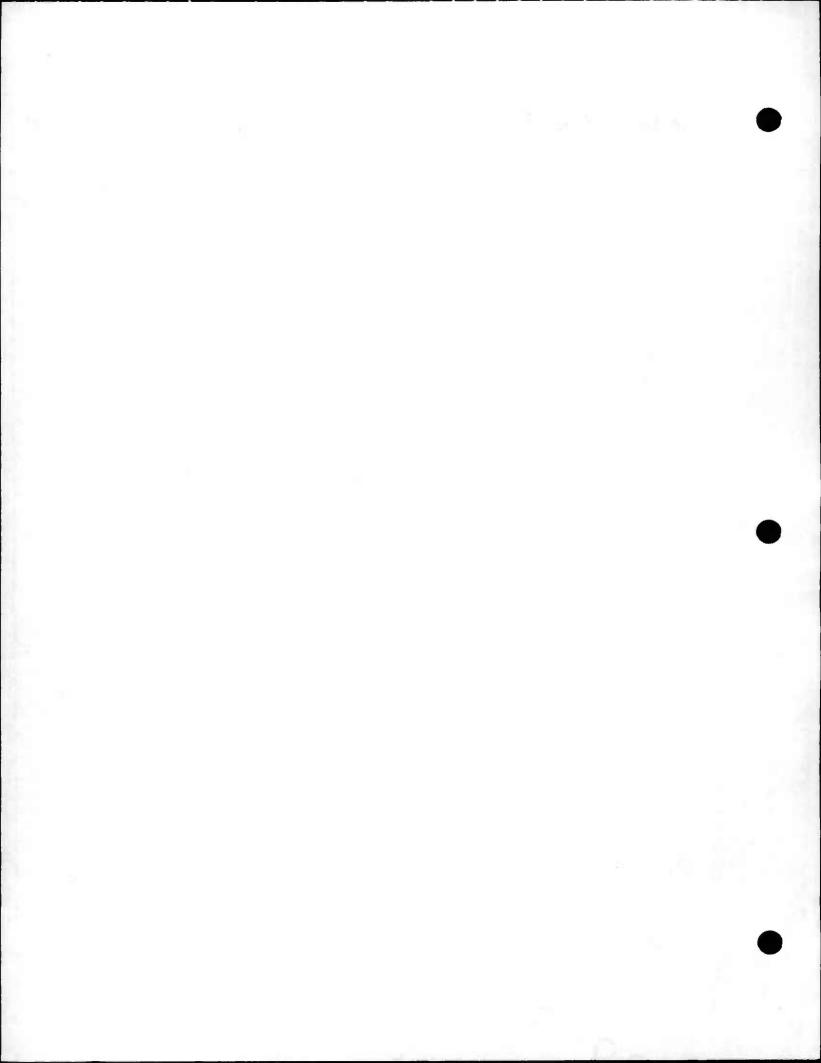


		FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR CERTIF	TMENT OF H	REALTH AND	MENT	AL HYGIENE REG. NO.						
	1	1. DECEDENT'S NAME (First, Middle, Lest)					2. DAT	E OF DEATH	,	EAR	3. TIME OF DEATN	-		
		4. SOCIAL SECURITY NUMBER	GETGER				API	RIL 25	1.9	995	6:40PM	_		
		217-09-1935	4 17 14 4 178 4	yrs. lest birthday)  YRS.	MONTHS DAYS	HOURS MIN.	(Mor	E OF BIRTN oth, Day, Year)		Country)	LACE (State or Foreign			
should		9a. FACILITY NAME (If not institution, give st		89						JAN 17, 1906 MARYLAND  ATH 9c. COUNTY OF DEATH				
2, 3 \$	СТОВ													
-	ECT	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY		10c. CIT	r, TOWN OR LOCAT			lN/A			_			
permit. Pages	RAL DIRE	MARYLAND N	I/A		ALTIMOR						18d. INSIDE CITY LIMITS? 1 X YES 2 NO			
		10e. STREET AND NUMBER				. ZIP CODE			10g. CITIZE		AT COUNTRY?	-		
020 physician. burial-transit	FUNER	3320 BENSON AV				21227				s.				
5-0020 nding physician. Is the burial-tran	B	1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 1 YES IF YES, GIVE WAR OR DAT	2 XNO	If yes, sp	ecity Cuben, Mexic  2 XNO Speci	en, Puerto	IN? (Specify Yes or Rican, etc.)	No- 14	Black, Specify	- American Indian, White, etc.			
21 afte	品	15. DECEDENT'S EDUC (Specify only highest grade	ATION completed)	18a. OECEOENT'S (Give kind of w	rork done during ma	ON ost of working	16	b. KINO OF BUSIN	ESS/INDUS	TRY		-		
5 5	LET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT us	e retired.)			G7 (	^ ~~~~					
The hospital detached for	COMPL	17. FATHER'S NAME (First, Middle, Lest)		SEAM	STRESS	18 MOTNED'S N	ME /First	Middle, Maiden Su	OTHIN	G		_		
8 E E	ш	JOSEPH SALK	AVICH			SEL		UNKNOW						
MAR retained 5 should	TO B	19a, INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a	ind Number or Rural				ode)		-		
. 2 2 0		CHARLES JESILIONI				O., ELLI								
for, tor,		208. METHOD OF DISPOSITION  126 Burial 2 Cremetion 3 Remo 4 Donation 5 Other (Specify)	val from State 20b.F	PLACE AND OATE O	PER DISPOSITION (Na her place)	ETERY AP	0A	TE 20c. LOCAT	000					
		21. SIGNATURILO FUNERAL SERVICE LIC	ENSEE	JI KEDEE	22. NAME AN	O ADDRESS OF FA	CILITY				ARYLAND	-		
BALTIN er death. Pag the funeral di val.		+ William ?	Atack.		STERI	LING ASH	TON :	FUNERAL	HOME	, IN	IC.			
by, P.O. BOX	CERTIFICATION	STERLING ASHTON FUNERAL HOME, INC 736 EDMONDSON AVE., BALTIMORE, M  23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  IMMEDIATE CAUSE (Finel disease or condition resulting in death)  There is a second and Infanction out the cause of the										on th		
uires that the signed by Health and ws any in	MEDICAL	PART II. Other significant conditions					Part i.	24a. WAS AN AU PERFORME 1 TYES 2	D2	0	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	5		
AL KE ne law requ has been bept. of n 23 sho	AN	DID TOBACCO USE CONTR				UNCERTAI	Ν□							
SICIAN: The certificate he the State he the	SCI	EXAMINER?	HOSPITAL:	B. PLACE OF OEAT	OTHER:							-		
YSICIA S certif	PHYSICI	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b, TIME	OF 28c. INJ			F (Specify) SCRIBE NOW INJU	JRY OCCUP	ED		-		
A SP	A	Natural 5 Pending Investigation			M 1 🗆 Y	RK? res 2 No								
DR ATTENDING PHYSICIAN: The DIRECTOR All and seem the Grate to the Care of the	E	3 Suicide 8 Could not be determined	26e. PLACE OF INJURY — building, etc. (Specify	At home, farm, st	treat, factory, office		28f. LOC City	CATION (Street and or Town, State)	Number or	Rural Roo	ite Number,			
4325	COMPL		IAN: To the best of my knowled On the bests of examination a							ause(a) c	and manner as stated.			
TO THE HOSPIT TO THE FUNERA De filed within ?	TO BE	29b. SIGNATURE AND TITLE OF CHRISTIER	Nedral	Res	deut	29c. LICENSE NO	MBER	29	DATE SI	GNEO (A	lonth, Day, Year)	-		
4		30. NAME AND ADDRESS OF PERSON WHO	1483B1	W 1 9 A	Print) Carto	n Are	E	SAGIN	NOR	15,1	MD2122	1		
		APR 2 8 1995	A AZ REMINISTRATION	Welath.						7		Ī		



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	THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page	
	Jeath. F	funeral	
1	after (	by the	moval.
	hours	ed in	Or re
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	within	pletely	filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI CERTIFIC	MENT OF H	DEATH AND MEI	NTAL HYGIEN REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, La		0.1			DATE OF DEATH	y v	3. TIME OF DEATH		
	Lauretta		Gilmo	re	1 A	eril 25	- 9	5 1:45 F		
	4. SOCIAL SECURITY NUMBER 212-28-2917	5. SEX 6. AGE		ONTHS DAYS	IF UNDER 24 HRS. 79	DATE OF BIRTH (Month, Day, Year)	8.	BIRTNPLACE (State or Foreign Country)		
	9a. FACILITY NAME (If not institution, give		67 yrs.			4-21-28		Maryland		
œ	St. Agnes Hospi		1	Baltim	OR LOCATION OF DEATH		9c. COUNTY	OF DEATN		
CTOR	RESIDENCE OF DECEDENT		n Ave.	partim	ore			VH		
2	10a. STATE 10b. COU	NTY	10c. CITY, 1	TOWN OR LOCAT	TION			10d. INSIDE CITY		
ō	Maryland		Bal	ltimore				LIMITS? 1 YES 2 NO		
ERAL	10e. STREET AND NUMBER	0.		101	ZIP CODE			N OF WNAT COUNTRY?		
E I	3707 W. Saratoga St.  11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARMED				21229		U.S	.A.		
FUN	1 Never Married 2 Merried	FORCES? 1 YES	2 XNO	If yes, sp	ENDENT OF NISPANIC O	RIOIN? (Specify Yea serto Rican, etc.)	or No 14	RACE — American Indian, Black, White, atc.		
BY	3 Widowed 4 KDivorced	IF YES, GIVE WAR OR D	DATES	1 TYES	2 XNO Specify:			Specify: black		
ED	15. DECEDENT'S E (Specify only highest gr		16a. DECEDENT'S US	SUAL OCCUPATION	ON ,	16b. KIND OF BUS	INESS/INDUS			
ET	Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work life. Do NOT use n	retired.)	st of working					
COMPL	12	4	Schoo1	Lteach	er	Educat	Lon			
8	17. FATNER'S NAME (First, Middle, Last)				16. MOTNER'S NAME (		Surname)			
BE	Nicholas Johnso	n			Laura Ma					
2	19a, INFORMANT'S NAME (Type/Print)				nd Number or Rural Route					
	Keith Gilmore				toga St.,			229		
	t ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 🖾 Donation 5 ☐ Other (Specify) _		b. PLACE AND DATE OF Contents of the contents		rme of	DATE 20c. LOC	CATION — City	y or Town, State		
	21. SIGNATURE OF PUNERAL SERVICE	LICENSEE		22. NAME AN	ID ADDRESS OF FACILIT	~				
	/ Janil	Ronald Wa	ade, Dir.			State A		y Board		
	20001/11/18	de			. Baltimor					
7	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cerdiec or respiretory arrest, shock, or heart feliure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition reaulting in death)  DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	Sequentielly list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):									
₹	PART li. Other significent conditi	ona contributing to death b	out not resulting in t	the underlying	ceuse given in Part					
DICAL	PART II. Other significent condition	ona contributing to death b	out not resulting in t	the underlying	ceuse given in Part	PERFOR	WED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
MEDICAL							WED?	AVAILABLE PRIOR TO		
MEDI	DID TOBACCO USE CON	NTRIBUTE TO CAUSE O	DF DEATH YES	□ NO □		PERFOR	WED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?		
MEDI	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	ITRIBUTE TO CAUSE O	OF DEATH YES 26. PLACE OF DEATH	□ NO □		PERFOR	WED?	AVAILABLE PRIOR TO COMPLETION OF CAUS OF DEATN?		
SICIAN: MEDI	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1   YES 2   NO	HOSPITAL:	DF DEATH YES 26. PLACE OF DEATH (	Check only one)  THER:  Nursing Nom	UNCERTAIN D	PERFORI	WED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?		
PHYSICIAN: MEDI	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1   YES 2   NO 27. MANNER OF DEATH Netural 5   Pending	HOSPITAL:   10 CAUSE O	OF DEATH YES 26. PLACE OF DEATH	(Check only one)  OTHER: Nursing Nom  OF 28c. INJ	UNCERTAIN 0	PERFORI	NED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO		
BY PHYSICIAN: MEDI	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH Netural 5 Pending 2 Accident Investigatio	ITRIBUTE TO CAUSE O	DF DEATH YES  26. PLACE OF DEATH ( Detient 3 DOA 4	(Check only one) THER: Nursing Nom WO 1 U	UNCERTAIN   5   Residence 6   USTY AT RK? ES 2   NO	PERFORI  1 YES 2  Other (Specify)  DESCRIBE HOW IN	JURY OCCUR	AMAILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH?  1  YES 2 NO		
ED BY PHYSICIAN: MEDI	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1  YES 2 NO 27. MANNER OF DEATH Netural 5 Pending	HOSPITAL: Inpetient 2 = ER/Outp  26a. DATE OF INJURY (Month, Dey, Year)  26a. PLACE OF INJURY building, etc. (Spec	DF DEATH YES  26. PLACE OF DEATH ( Detient 3 DOA 4	(Check only one) THER: Nursing Nom WO 1 U	UNCERTAIN   5   Residence 6   USTY AT RK? ES 2   NO	PERFORI 1  YES 2	JURY OCCUR	AMAILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH?  1  YES 2 NO		
ETED BY PHYSICIAN: MEDI	DID TOBACCO USE CON  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be detarmined	TRIBUTE TO CAUSE O  HOSPITAL: Impetient 2 = ER/Outp  26e. DATE OF INJURY (Month, Dey, Year)  26e. PLACE OF INJURY building, etc. (Spec	DF DEATH YES  26. PLACE OF DEATN ( Destlerit 3 DOA 4  26b. TIME 0 INJURY	Check only one)  THER: Nursing Nom Nursing Nursing Nom Nursing Nom Nursing Nursing Nom Nursing Nur	UNCERTAIN D  5   Residence 6    UNCY AT RKY (ES 2   NO    281,	Other (Specify)  Describe How In  LOCATION (Street as City or Town, State)	JURY OCCUR	AMAILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH?  1  YES 2 NO		
ETED BY PHYSICIAN: MEDI	DID TOBACCO USE CON  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	TRIBUTE TO CAUSE OF TALE AND	DF DEATH YES  26. PLACE OF DEATN ( Desting 3 DOA 4  26b. TIME 0 INJURY  27 At home, farm, stre- city)	Check only one)  THER: Nursing Nom Nursing Nom 1 V N 1 V N at factory, office	UNCERTAIN D  = 5   Residence 6   UNCERTAIN D  = 5   Residence 6   UNCERTAIN D  = 28d  = 28d  and place, and due to the	Other (Specify)  DESCRIBE HOW IN  LOCATION (Street as City or Town, State)	JURY OCCUR	AWAILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH?  1 YES 2 NO  NO  Rural Route Number,		
COMPLETED BY PHYSICIAN: MEDI	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	TRIBUTE TO CAUSE OF INJURY (Month, Dey, Year)  26a. DATE OF INJURY (Month, Dey, Year)  26a. PLACE OF INJURY building, etc. (Special Control of the best of my know INER: On the basis of examination	DF DEATH YES  26. PLACE OF DEATN ( Desting 3 DOA 4  26b. TIME 0 INJURY  27 At home, farm, stre- city)	Check only one)  THER: Nursing Nom Nursing Nom 1 V N 1 V N at factory, office	UNCERTAIN D  5 Residence 6 UNY AT RK?  VES 2 NO  28f.  and place, and due to the meath occured at the time,	Other (Specify)  DESCRIBE HOW IN  LOCATION (Street as City or Town, State)	JURY OCCUR	AWAILABLE PRIOR TO COMPLETION OF CAUSI DF DEATH?  1  YES 2 NO  Rural Route Number,		
BE COMPLETED BY PHYSICIAN: MEDI	DID TOBACCO USE CON  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	TRIBUTE TO CAUSE OF INJURY (Month, Dey, Year)  26a. DATE OF INJURY (Month, Dey, Year)  26a. PLACE OF INJURY building, etc. (Special Control of the best of my know INER: On the basis of examination	DF DEATH YES  26. PLACE OF DEATN ( Desting 3 DOA 4  26b. TIME 0 INJURY  27 At home, farm, stre- city)	Check only one)  THER: Nursing Nom Nursing Nom 1 V N 1 V N at factory, office	UNCERTAIN D  = 5   Residence 6   UNCERTAIN D  = 5   Residence 6   UNCERTAIN D  = 28d  = 28d  and place, and due to the	Other (Specify)  DESCRIBE HOW IN  LOCATION (Street as City or Town, State)	JURY OCCUR	COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO  Rural Route Number,  Buse(e) and manner as stated.  GNED (Month, Day, Year)		
COMPLETED BY PHYSICIAN: MEDI	DID TOBACCO USE CON  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES 2   NO  27. MANNER OF DEATH    Netural   5   Pending Investigation   Pending Investigation   Pending Investigation	TRIBUTE TO CAUSE O  HOSPITAL: Impetient 2 = EP/Outp  28a. DATE OF INJURY (Month, Dey, Year)  28a. PLACE OF INJURY building, etc. (Spec	DF DEATH YES  26. PLACE OF DEATH ( patient 3 DOA 4  266. TIME O INJURY  27— At home, farm, stre- city)  RESI D.	(Check only one) ITHER: Nursing Nom Nursing Nom Nursing Nom I y M I y oet, factory, office at the time, data In my opinion, de	UNCERTAIN D  5 Residence 6 UNY AT RK?  VES 2 NO  28f.  and place, and due to the meath occured at the time,	Other (Specify)  DESCRIBE HOW IN  LOCATION (Street as City or Town, State)	JURY OCCUR	AWAILABLE PRIOR TO COMPLETION OF CAUSI DF DEATH?  1  YES 2 NO  Rural Route Number,  Buee(e) end manner as stated  GNED (Month, Dey, Year)		
BE COMPLETED BY PHYSICIAN: MEDI	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	TRIBUTE TO CAUSE O  HOSPITAL: Impetient 2 = EP/Outp  28a. DATE OF INJURY (Month, Dey, Year)  28a. PLACE OF INJURY building, etc. (Spec	DF DEATH YES  26. PLACE OF DEATH ( patient 3 DOA 4  266. TIME O INJURY  27— At home, farm, stre- city)  RESI D.	(Check only one) ITHER: Nursing Nom Nursing Nom Nursing Nom I y M I y oet, factory, office at the time, data In my opinion, de	UNCERTAIN D  5 Residence 6 UNY AT RK?  VES 2 NO  28f.  and place, and due to the meath occured at the time,	Other (Specify)  DESCRIBE HOW IN  LOCATION (Street as City or Town, State)	JURY OCCUR  There as stated, due to the cr	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO  Rural Route Number,		



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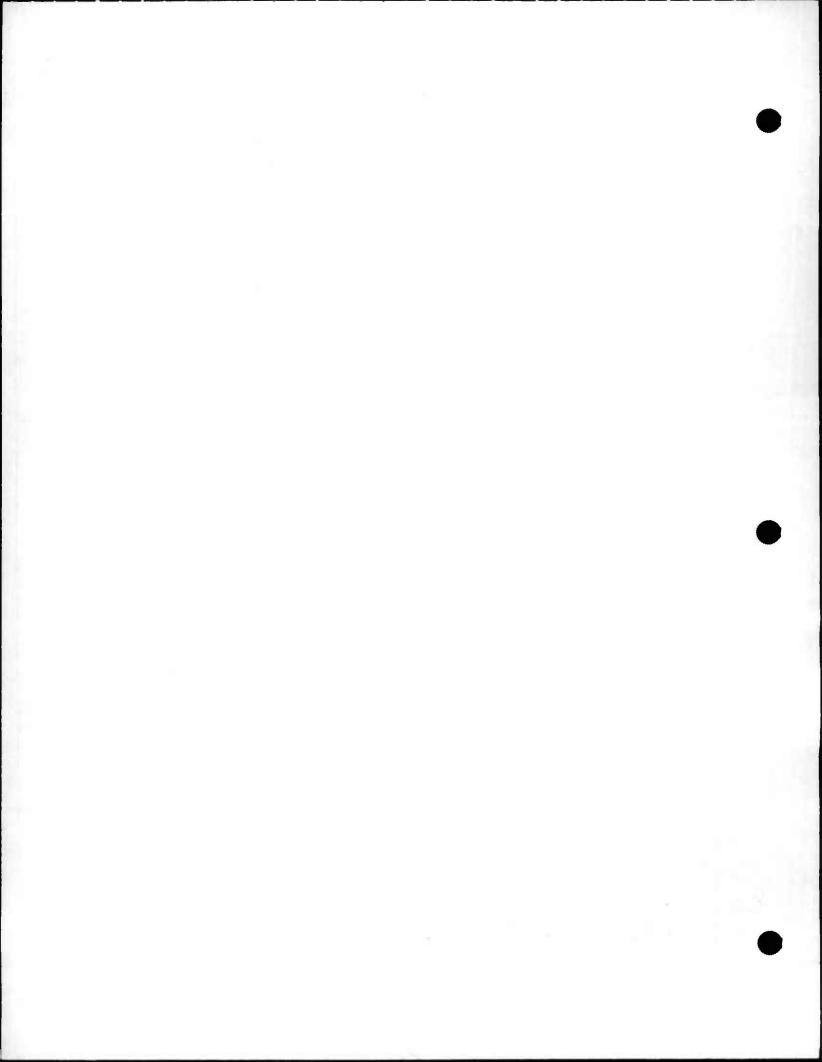
FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First Middle Last) 3. TIME OF DEATH 2. DATE OF DEATH 155 PM JOHN MARTIN GILDAN

4. SOCIAL SECURITY NUMBER

5. SEX April 7. DATE OF BIRTH (Month, Day, Year) 8. AGE (In vrs. last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 1X M 2 | F 213-09-3881 81 12-5-1913 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Stella Maris Hospice Towson Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Dundalk permit. 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 7933 Wise Ave use as the bunial-transit 21222 USA hours after death. Page 6 may be retained by the hospital or attending physician. sof in by the funeral director, page 5 should be detached for use as the buriat-tran 11 MADITAL STATUS 12. WAS DECEDENT EVER IN U.S. ABMED FORCES? 1 YES 2 XNO WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—if yea, specify Cuban, Maxican, Puarto Rican, atc.)
 U YES 2 NO Specify: BALTIMORE, MARYLAND 21215-0020 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 8 Crane Operator Beth - Steel once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Ħ Joseph Guldan BE Amelia Hodulik notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Ernestine Guldan 7933 Wise Ave Baltimore, Md 21222 9 20s. METHOD OF DISPOSITION
1 Å Burlet 2 □ Cremation 3 □ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Nama of Cem. DATE 20c. LOCATION - City or Town, State must 4 Donation 5 Other (Specify) Jesus 4-29 Baltimore, Md Heart of examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Dundalk filled in by the fi 7110 Sollers Point Rd medical 23. PART i. Enter the disease, or complications that ceused the design shock, or hear failure. Liet only one cause on each life. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximats completely filled In rial, cremation, or Interval Between **IMMEDIATE CAUSE (Final** Onsat and Death the disease or condition CANCER OSTATE resulting in death) event. burial, traumatic CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) the attending physician ar If any, leading to immediate cause. Enter UNDERLYING that the death certificate be other t CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS certificate has been signed by the State Dept. of Health and AVAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? any 1 TES 2 NO requires shows : 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN ME 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only on Item EXAMINER? HOSPITAL: OTHER:
4 □ Nursing Home 5 □ Rasidence 6 XOther (Specify) 1 TES 2 NO OR ATTENDING PHYSICIAN: 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 27. MANNER OF BEATH 28a. DATE OF INJURY 26b. TIME OF INJURY 28c. INJURY AT WORK? this c 28d. DESCRIBE HOW INJURY OCCURED marked, Natural 2 Accident 1 YES 2 NO BY After Investigation OIRECTOR: Aff hours after de-Item 28 Is r 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town. State) 6 Could not be determined COMPLETED 4 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL OIRECTE DE filed within 72 hours at IMPORTANT; It (tem 2) 29a. CERTIFIER

CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(a) and manner as attend. MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 14/26 ullino 2564 195 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2300 DULANEY VALLEY ROAD TOWSON, MD 21204 DR. KENDALL FAULKNER 31. DATE FILED (Month, Day, 16er)
APR 2 8 1995 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



BALTIMORE, MARYLAND 21215-0020

notified at

TO THE HOSPITA
TO THE FUNERA
De filed within

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Pages 1, 2, 3 should

permit.

burial-transit

DIVISION OF VITAL RECORDS, P.O. BOX 68760

HOSPITAL OF TEMBRIS PHYSICIAN: The law requires that the death certificate be executed within-24 hours after death. Page 6 may be retained by the hospital or attending	FUNE NATION FROM this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the	ept. of Health and Mental Hygiene prior to burial, cremation, or removal.	TANT: I man of is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
equires that	en signed b	of Health ar	hows any
The law i	te has be	ite Dept.	em 23 s
ICIAN:	certifica	the Str	or it
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HOSPITA	FUNERA	within	TANT

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 ETHEL LEONA HOHENBERGER 5:20 P. M APRIL 25, 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign (Month, Day, Year) SEPT. 20, 1907 218-03-6349 1 M 2 X F 87 MARYLAND 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR HERITAGE NURSING HOME DUNDALK BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE CITY BALTIMORE 1 X YES 2 NO FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1730 WILMINGTON AVENUE 21230 U.S.A. 12. WAS DECEDENT EVER IN U.S. ABMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yea or No—
If yea, specify Cuban, Maxican, Puerto Rican, atc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Married BY 3 X Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. OECEOENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY most of working Elemantary/Secondary (0-12) College (1-4 or 5+) 8TH GRADE HOMEMAKER HOMEMAKING 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) HOWARD COLLISON BE CORA THOMAS 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 CARL HOHENBERGER 296 WINTERBERRY LANE - WESTMINSTER, MD 21157 METHOD OF DISPOSITION 20s. METHOD OF DISPUSITION
1 M Burlet 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State WESTERN CEMETERY Donation 5 - Other (Specify) 4/28 BALTIMORE 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate List only ona ceuse on each lina. shock, or haert fallure. interval Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition_ HEIME YRS resulting in death) OUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially liet conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO CDMPLETION DF CAUSE DF DEATH? 1 TYES 2 NO 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🗵 UNCERTAIN 🗆 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER:
4 🖾 Nursing Home 5 🗆 Residence 8 🗆 Other (Specify) 1 TYES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 27, MANNER OF OEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT 26d. OEȘCRIBE HOW INJURY OCCUREO 1 Natural
2 Accident 5 Pending BY 1 YES 2 NO Investigation CATE 3 Sulcide 28a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide 29e. CERTIFIER 1 KCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) end manner as stated. COMP 2 MEDICAL EXAMINER: On the beele of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

Lamanne, mos 7 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. K. DHARMASENA - 710 CHURCH STREET - BALTIMORE,

29c. LICENSE NUMBER

MARYLAND

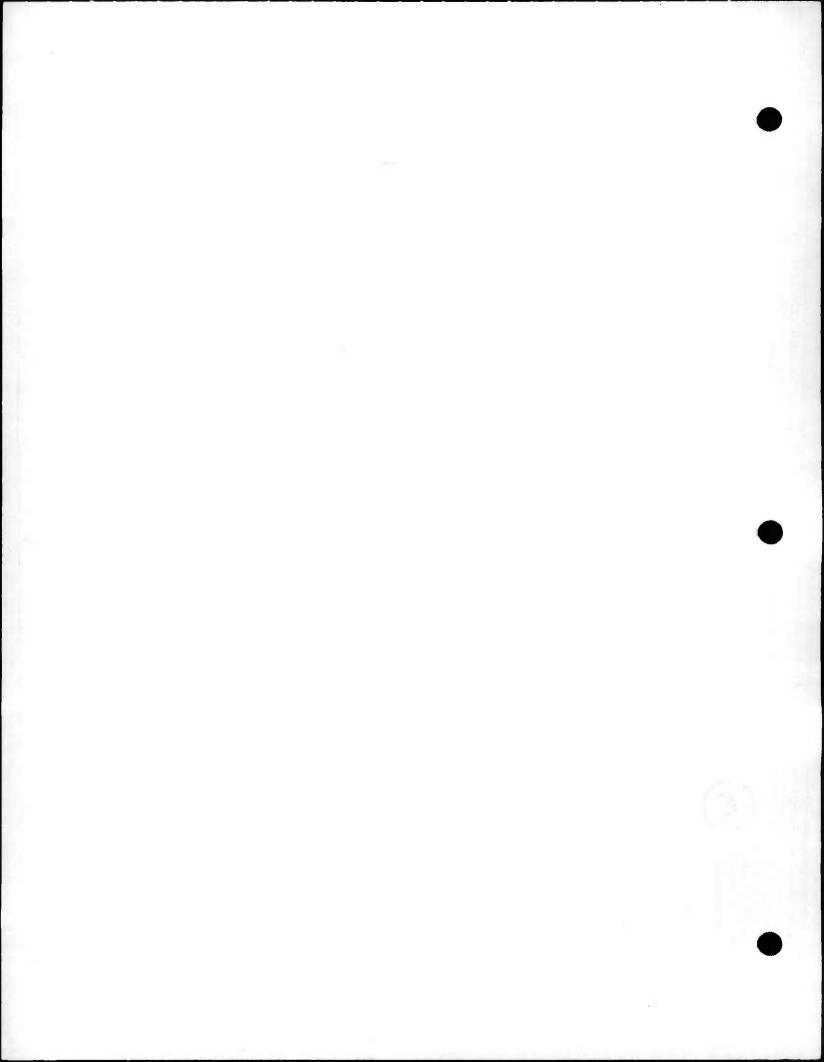
31. DATE FILED (Month, Day, Year) 32 REGISTRAR'S SIGNATURE APR 2 8 1995

296. SIGNATURE AND TITLE OF CERTIFIER

29d. DATE SIONED (Month, Day, Year)

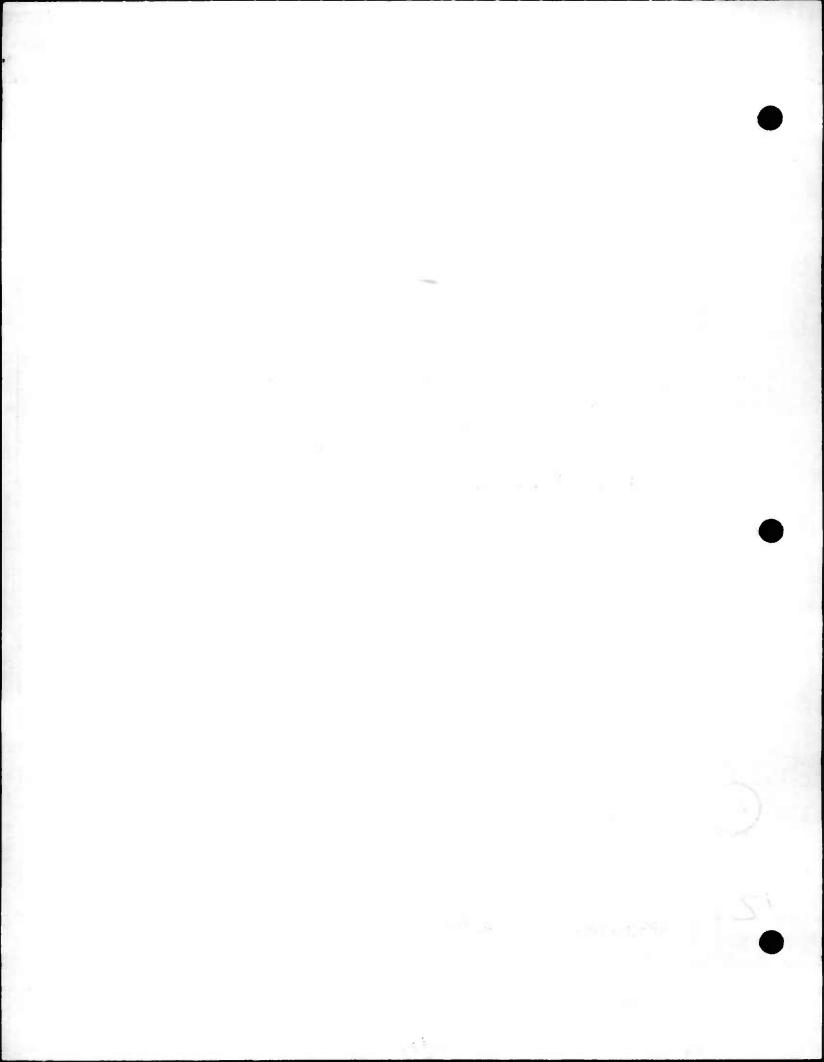
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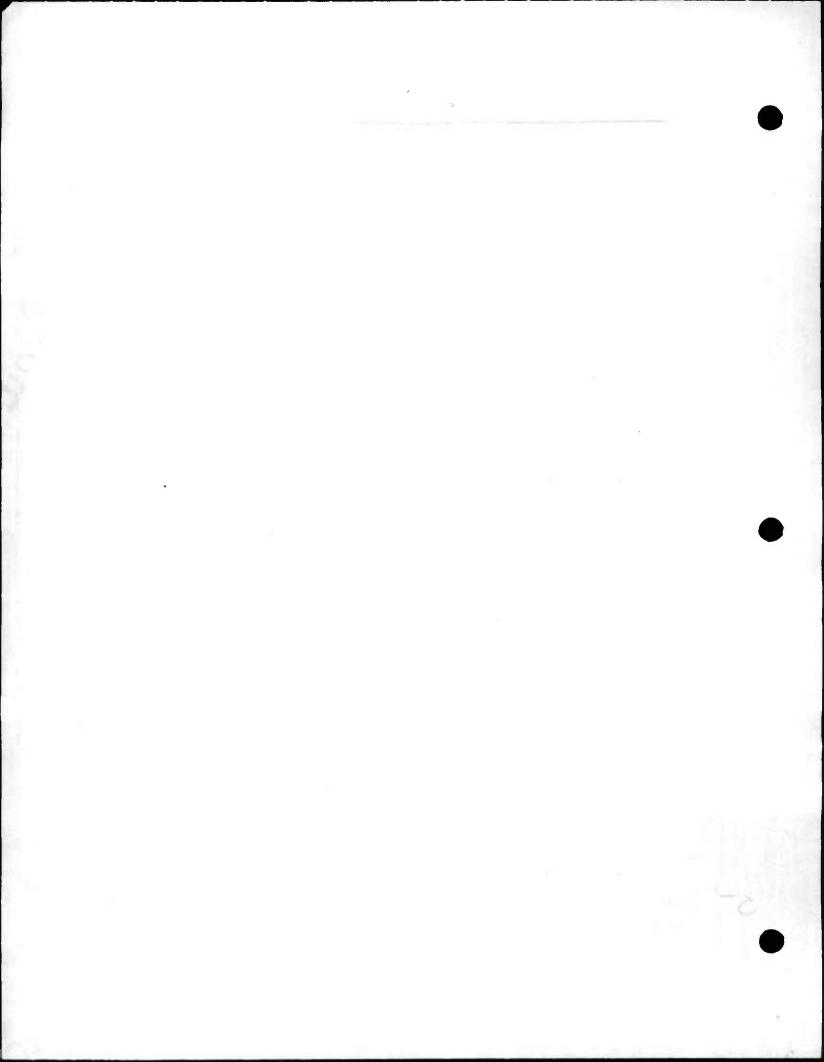
DHMH-16 Rev 1/89

		1 - STATE REGISTRAR	STATE OF MARY					HEALTH DEAT			GIENE G. NO.		
		1. DECEDENT'S NAME (First, Middle, Lest)	T- Ha	10		10		V		2. DATE OF DE	ATH DAY	WEAR	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	E (In yrs. las	at birthday)	IF UNDER	1 YEAR	IF UNDER	94 HRS.	7 DATE OF BIO	AD ~ ~ 0	95 8 BIRTHP	PLACE (State or Foreign
_		215-07-1410	1 [X M 2 □ F	78	YRS.	MONTHS	DAYB	HOURS	MIN.	Oct 6	Year)	Country)	yland
pjnoys	_	9a. FACILITY NAME (If not institution, give					TOWN C	OR LOCATIO	ON OF DE			UNTY OF DE	
2, 3	5	Johns Hopkins	Bayview Me	≥d. (	Ctr.	J	Ba 1 t	timo	re		N/	/A	
ages 1,	DIRECTOR	10e. STATE 10b. COUNT			10c. CIT	TY, TOWN O	OR LOCAT	ION					10d. INSIDE CITY LIMITS?
permit. Pages	1 1	Md. Ba	1timore			Dunda1k							1 YES 2 NO
	FUNERAL	3455 Yorkway						1. ZIP COOE 2122		10g. CITIZEN OF			
15-0020 ending physician. as the burial-transit	N.	11. MARITAL STATUS	12. WAS DECEDENT EVER	R IN U.S. AF	RMEO		WAS DEC	ENDENT O	F HISPANI	HC ORIGIN? (Spec	city Yes or No-	14. RACE -	- American Indian.
215-0020 attending physic	BY F	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES	DATES	T.			ecify Cubar 2V NO		n, Puerto Rican, a /:	Mc.)	Specify	
215-0 attending se as the		15. DECEOENT'S EDU	UCATION	16a, DE	CEDENT'S	USUAL OC	CCUPATIC	ON		16b. KINO	OF BUSINESS/IN	Whit	;e
21 If or	COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(G	ive kind of a b. Do NOT us	work done o	during mos	ost of working	g				
AND 2 the hospital detached fo	OMP.	12 yrs 17. FATHER'S NAME (First, Middle, Lest)			Car	pent	er				te of		'land
YLA by the be det	E CC	Edwin Hall								ME (First, Middle, I ie Sea			
MARYLAND retained by the hospits 5 should be detached notified at once.	TO BE	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS	S (Street a	and Number	or Runal Ro	Route Number, City	or Town, State, Zi	(ip Code)	
E, M	١	Dorothy Hall					-		Dunc		Md. 21	1222	
C E 5 E		20a. METHOD OF DISPOSITION 1 Department Survey Surv	noval from State	emetery, cre	emetory or o	ther place!				1	O.E. D. a.1		
ALTIMO death. Page 6 funeral directe		21. SIGNATURE OF FUNERAL SERVICE LI	ICENSEE	hesc	ipea	22.1	NAME AN	ND ADORES	SS OF FAC	CHITY			11e, Md.
ALTIN death. Pag e funeral dir il. examiner		7 m mil3 1	> L			Br 21	:adl   34	ey-	Asht	ton Fu	neral	Home	21222 co.,Md.
s aft		23. PART i. Enter the diseases, or	complications that cause	ed the de	ath. Do r	not enter	the mo	de of dyl	ng, such	as cerdiec or	reepiratory ar	rreet,	Approximate
y filled in the med		IMMEDIATE CAUSE (Final	Liet only one ceuse on	each line	•								Interval Between Onset and Death
a see		disease or condition resulting in death)	a Hypo	XI	A CHIENCE O								18
x 68760 executed with and complet o burial, cren	Z		COPD	A CONSEC	JUENUE U	i):							1hors
OX 68: e be execute sician and c nior to buria traumatic	CATION	Sequentially list conditions, if any, leading to immediate	OUE TO (OR AS	A CONSEC	QUENCE OF	F): '							7
O. BC ertificate to ing physici giene prio other tra	SE	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	c. PNUU DUE TO (OR AS	m (	37V	CO							d weeks
0 + 10 E	CERTIFI	that initieted events resulting in death) LAST	4	A 00,	Position 1.	7.							
TOS, P the death by the atten of Mental H		PART II. Other eignificant condition	ne contributing to death	but not r	emulting	In the un	deriving	Cause C	alven in F	Dart I 24n Y	MAS AN AUTOPSY	245.1	THE ALITHDRY FAIRING
C = 65 -	DICAL				ocurre.	II tilo a	uerry		19011 111 .	P	PERFORMED?	â	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
S 2 2 2 2	MED						,				YES 2 □ NO		OF DEATH?
L faw faw as b ept.		DID TOBACCO USE CONT	RIBUTE TO CAUSE (					UNC	ERTAIN				
E # # E	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			TH (Check o	3:	W					
ertification of the	HYS	1 TYES 2 THO  27. MANNER OF DEATH	1 Dipetient 2 ER/Out 28a. DATE OF INJURY	Y	28b. TIM	E OF	28c. INJU	URY AT	-	6 Other (Specification of the Control of the Contro	HOW INJURY OC	CURED	
NG PHYS ter this tath with	ВУ Р	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)			JURY	WOR	RK7 rES 2 🗌					
SION SION Mer marth	<b>a</b>	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJUR building, atc. (Spe	RY — At hor secify)	me, farm, s	streel, facto	ary, office	,		281. LOCATION (: City or Town,	(Street and Number , State)	r or Rural Rou	ute Number,
2 7 7 2	Ē	On OFFICIEN		OVER 12									
NEW Y	MP.		SICIAN: To the best of my know ER: On the basis of examination										and manner as stated.
TO THE HOSP TO THE FUNE be filed within	E C0	296, SIGNATURE AND TITLE OF CERTIFIE			0		_		NSE NUMB		_		Month, Day, Year)
다 다 다 하 하 하 하 하 하 하 하 하 하 하 하 하 하 하 하 하	TO BI	(pmon	R, tan	ell	11	W	$\supset$	94	1010	4	<b>&gt;</b> (	4/25	5/95
1 -7	- 1	30. NAME AND ADDRESS OF PERSON WH	HO COMPLETEO CAUSE OF DE	10	M 27) (Type,		140	7-	24	1	R	11.	010
' _	1	31. DATE FILED (Month, Day, Year)	321 BEGISTRAR'S OG	- 1	VU	77	70	Ca	516	ernAu	e mu	MM	oce, vill
		APR 2 8 1995	My dimension	Mall									



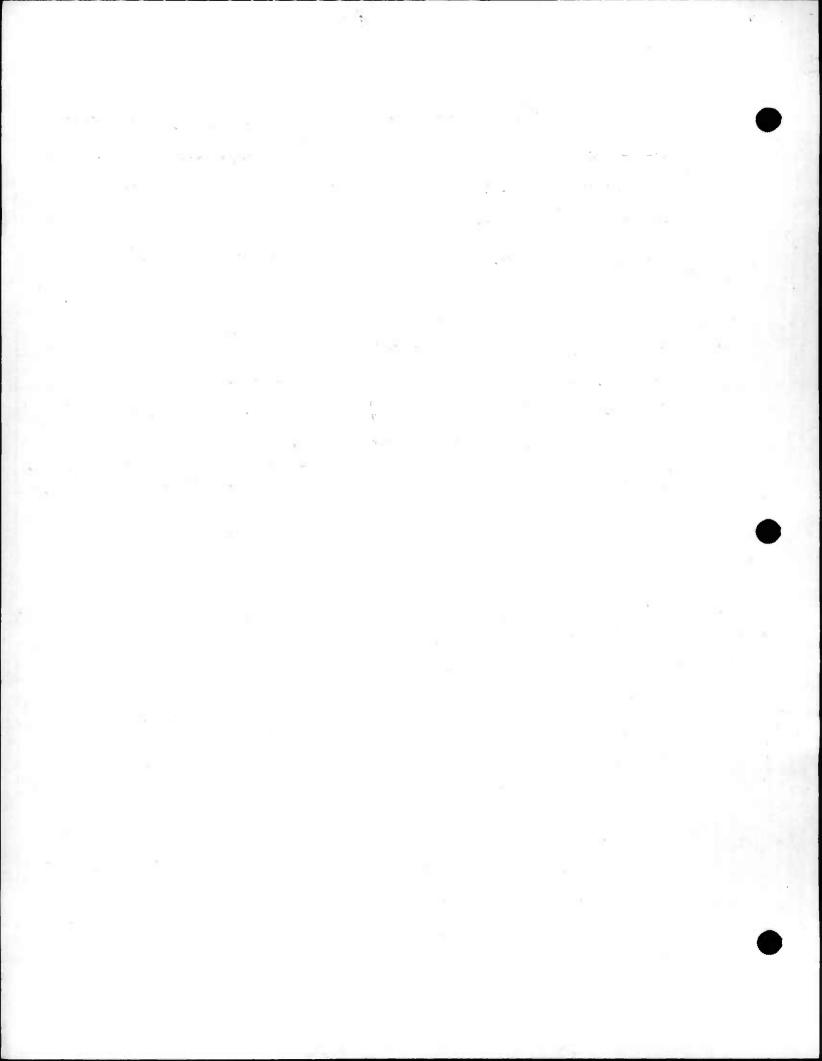
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit before the filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
9 B
4 hours after death. Pagilled in by the funeral di

	Item#1. G-film 722	-, ,		1.44		_						
	1 - STATE REGISTRAR	STATE OF	MARYLAND /	DEPAR ERTIF	TMENT (	F HEALT	H AND	MENTA	L HYGIE			
	1. DECEDENT'S NAME (First, Middle, Last)	Viola Vi	rginia	Henne	man			2. DATE	E OF DEATH		WEAR	3. TIME OF DEATH
		Viola Vi			AN			AP	RIL	23 1	995-	06 25 AM
	4. SOCIAL SECURITY NUMBER 214-03-0660	5. SEX	B. AGE (In yrs. In		IF UNDER 1 Y	EAR IF UN	DER 24 HRS.	(Mon	OF BIRTH		8. BIRTH	PLACE (State or Foreign
	9a. FACILITY NAME (If not institution, give str		79	YRS.			11		t. 9			laryland
œ.	St. Agnes Hos				96. CITY, TO	WN OR LOC				9c, COUN	TY OF OE	ATH
DIRECTOR	RESIDENCE OF DECEDENT	Pitai				В	altimo	ore			_ r	V   FF
E	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR I	OCATION						10d. INSIDE CITY LIMITS?
	Maryland Balti	more		Cat	onsvi	· · · · · · · · · · · · · · · · · · ·						1 TES 2 NO
RA		en Choice Ln. 101. ZIP CODE 109. CITIZEN OF WHAT COUNT										HAT COUNTRY?
FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN	IT EVER IN U.S. AF	MED	13. WAS	2122		NIC ORIGI	N? (Specify Y	na or No I	SA 14 BACE	- American Indian.
BY F	1 Never Merried 2 Married 3 Wildowed 4 Divorced	FORCES?	MAR OR DATES	NO	If ye	s, specify Cu YES 2 XI	ıban, Mexic	an, Puello	Rican, atc.)		Black, Specif	, White, etc.
	15. DECEDENT'S EDUC	471041	1123									Wille
ETE	(Specify only highest grade of	completed)	(G	CEDENT'S live kind of v Do NOT us	USUAL OCCU vork done during ne retired.)	PATION og most of wo	rking	161	b. KIND OF B	JSINESS/INO	USTRY	
P	12	College (1-4 or 5		Home	maker				Own	Home		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. M	OTHER'S N	AME (First,	Middle, Maide		-	
BE	George Carroll	Dunawa	Ту				Mar	y Li	llie Mo	ore		
TO BE COM	190. INFORMANT'S NAME (Type/Print)  Charles A. Henne		19		ADDRESS (S)						-	
	20a. METHOD OF DISPOSITION	eman	100000000000000000000000000000000000000				or Dr					D 21136
	Constion 5 Other (Supplement)	val from State	cemetery, ere	matory or at	her place)			OAT		OCATION — C		2000000
	21. SIGNATURE OF FUNERAL SERVICE LICE	INGER	lividys	CHap	e Ce	M . IE AND AOD			95 1	imoni	um,	MD
	Lowell M. Lefa	mon Z	200			mon						
	23. PART I, Enter the diseases, or co	matications the	t caused the de	esth. Do n	ot enter the	wode of	adoni	a Kc	d., 11	moniu	m, A	MD 21093
	ahock, or heart failure. L	lat only one cau	use on each line	).	ot untar the	mode of t	aynig, suc	on as car	diac or resp	orratory arre	eat,	Approximate interval Between
		MYO	CARN	IAL	12	FAR	CT	101	3			Onset and Desth
	readiting in death)	DUE TO	(OR AS A CONSE	DUENCE OF	7:	7 111		, ,				d 01/2
NO	Sequentially list conditions, b.	MYO DUE TO PERF	ORAT	←∨	PE	PT	IC	OL	- CE	~		3 DAYS
ATI	if any, leading to immediate		(OR AS A CONSE		,-							
FIC	CAUSE (Disease or Injury that initiated events	HYP CH DUE TO	(OR AS A CONSE	DUENCE OF	):							YGARS
CERTIFICATION	resulting in death) LAST	DIAS	ETES									YEARS
CC	PART ii. Other significant conditions	contributing to	death but not :	egultino l	n the under	iving cour	gives I-	Dart I	240 1110	ALEWS BALL	1 411	
			Couli Bot Hot I	counting i	ii tiie diidai	lynig cous	a Aisau iu	Paint I.	PERFO	RMED?		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC									1 TYES	2 NO		OF DEATH?
ż	DID TOBACCO USE CONTRI	IBUTE TO CA	USE OF DEA	TH YE	S D NO	□ UN	ICERTAI	NA				1 TES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL				H (Check only			. 7 _ ]				
YSI	1 TYES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER:	Home 5 🗆	Residence	6 🗆 Othe	F (Specify)			
	27. MANNER OF DEATH  1 Netural 5 Pending	28e. DATE OF (Month, D		28b. TIME	URY	INJURY AT WORK?		28d. DE	SCRIBE HOW	INJURY OCC	URED	
B	Accident Investigation	28a PLACE O	F INJURY — At ho	me term o		YES 2	□ NO					
8	4 Homicide 8 Could not be determined	building,	atc. (Specify)	,	ileet, lactory,	Offica		City	ATION (Street or Town, State	and Number (	or Rurel Ro	oute Number,
삗	29a. CERTIFIER 1 CERTIFYING PHYSICI	AN: To the heat of	my knowledne de	eth accurre	d at the time	data and at-						
COMPLET												end menner ee stated.
ECC	296, SIGNAPHRE AND TITLE OF CERTIFIER	1 2 2					CENSE NUI					Month, Day, Year)
( m	- Demist	- n>					188					- 23 1955
2	30 NAME AND ADDRESS OF PERSON WHO	A	SE OF DEATH (ITE									
	GRIK STANCOFS		(>	700	CAT	م در	NE	SA	runn	ore	No	2,229
	APR 2 8 1995		R'S SIGNATURE									
	100 1000	- The section	nardall									l l



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		1 - FOR STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTM			MENTA	L HYGIENE REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)	David Lee Hag	iy, Sr.			MONT	of DEATH DAY	1995 [°]	AB	e of death
pin		4. SOCIAL SECURITY NUMBER  214-56-8364  9a. FACILITY NAME (# not institution, give st	1 № M 2 🗆 F 43	YRS. MO	UNDER 1 YEAR WITHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE (Mont	OF BIRTH th, Day, Year) 9,1951	6, 8	BIRTHPLACE Country) MCU	: (State or Foreign Tyland
. 2. 3 should	TOR	7901 Trappe Road RESIDENCE OF DECEDENT		96.		dalk	PEATH	90	Bala	of death timore	2
Pages 1,	DIRECTOR	10a. STATE 10b. COUNTY Maryland		10c. CITY, TO	OWN OR LOCA	Dun	dalk			0	NSIDE CITY LIMITS? YES XX NO
sit permit.	3AL	100. STREET AND NUMBER 7901 Trappe Road	1 Ant D		101	ZIP CODE	222	10-		of what c	OUNTRY?
215-0020 attending physician. ise as the burial-transit	BY FUNER	11. MARITAL STATUS  1 Never Married 2 Married  3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 ☐ YES IF YES, GIVE WAR OR DATE	2) XNO	If yes, sp		NIC ORIGI	N? (Specify Yea or N Rican, etc.)	io— 14.	RACE - Am Black, White	erican Indian.
or afte	ETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)		Se. DECEDENT'S USU (Give kind of work life. Do NOT use ret	done during mo	ON st of working	168	. KIND OF BUSINES	SS/INDUST		
AND 2 the hospital detached fo	COMPL	6 Years 17. FATHER'S NAME (First, Middle, Last)		Crane 0	perato.			Steel		stry	
8 E 2	E CC	Warren F. Hagu						Middle, Maiden Sum Knowles	ame)		
MAR retained 5 should notified	TO BI	19a. INFORMANT'S NAME (Type/Print)				nd Number or Rural	Route Num	ber, City or Town, Ste			
De S	-	Doris M. Curd 200. METHOD OF DISPOSITION						Dundal	-		
IMORE Page 6 may Il director, pa		1 Buriel 2 Cremetion 3 Remo	val from State 20b. Pl	ACE AND DATE OF DI	ISPOSITION (NE DIACE) ULC. C. C.	oro 4/		E 20c, LOCATION TOWS			de
SALT r death. ne funera al. examil		21. SIGNATURE OF FUNERAL SERVICE LIC			22. NAME AI	da-Ruck	Fune	ral Home Dundal	061	Dundal	2k, Inc.
Sc.  1 within 24 hours after mpletely filled in by the cremation, or removal event, the medical		23. PART I. Enter the disagrees, or callock, or heart fellure. I IMMEDIATE CAUSE (Finel disease or condition resulting in death)	list Drily one ceuse on each	stati					ry errest,		Approximata Intarval Between Onsat and Death
. BOX 687 ificate be executed physician and column and column and column to burial ther traumatic in	IFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CO								
OS, P.O. or death cert the attending Mental Hygis Ilury, or ot	CERTIFIC	resulting in death) LAST	•								
that the the that the the the the the the the the the th	MEDICAL	PART II. Other significent conditions	contributing to deeth but	not resulting in th	e underlyin	ceuse given in	Part I.	24a. WAS AN AUTO PERFORMED 1 YES 2 X P	?	AMAILA COMPL OF DE	
St. of	N.	DID TOBACCO USE CONTR	BUTE TO CAUSE OF	DEATH YES	□ NO □	] UNCERTAI	N &X			1 🗆 Y	res 2 🗍 NO
	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	26. HOSPITAL: 1   Inpatient 2   ER/Outpatie	PLACE OF DEATH (C	HER:	e 5 [XRaeldence	6 Cothe	or (Specify)			
NG PHYSICIA fer this certification with the marked, or		27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	26c. INJ WO	URY AT		CRIBE HOW INJUR	Y OCCURE	D	
TTENDI TOR: A after d	red BY	Accident Investigation  3 Suicide 6 Could not be determined	26s. PLACE OF INJURY — building, atc. (Specify)	At home, ferm, street		/ES 2 NO	26f. LOC City	ATION (Street and N or Town, State)	umber or R	ural Floute Nu	ımber,
A OR	COMPLET		IAN: To the best of my knowleds:							use(s) and m	nenner as stated.
TO THE HOSPITAL TO THE FUNERAL be filed within 72 I	H	296. SIGNATURE AND TITLE OF CERTIFIER	Hudubyr	ч		29c. LICENSE NU		290		NED (Month,	
1	10	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	1 // 1/		Mo	-		,		
		APR 2 8 1995	22. REGISTRAR'S SIGNATURA	IRE /							

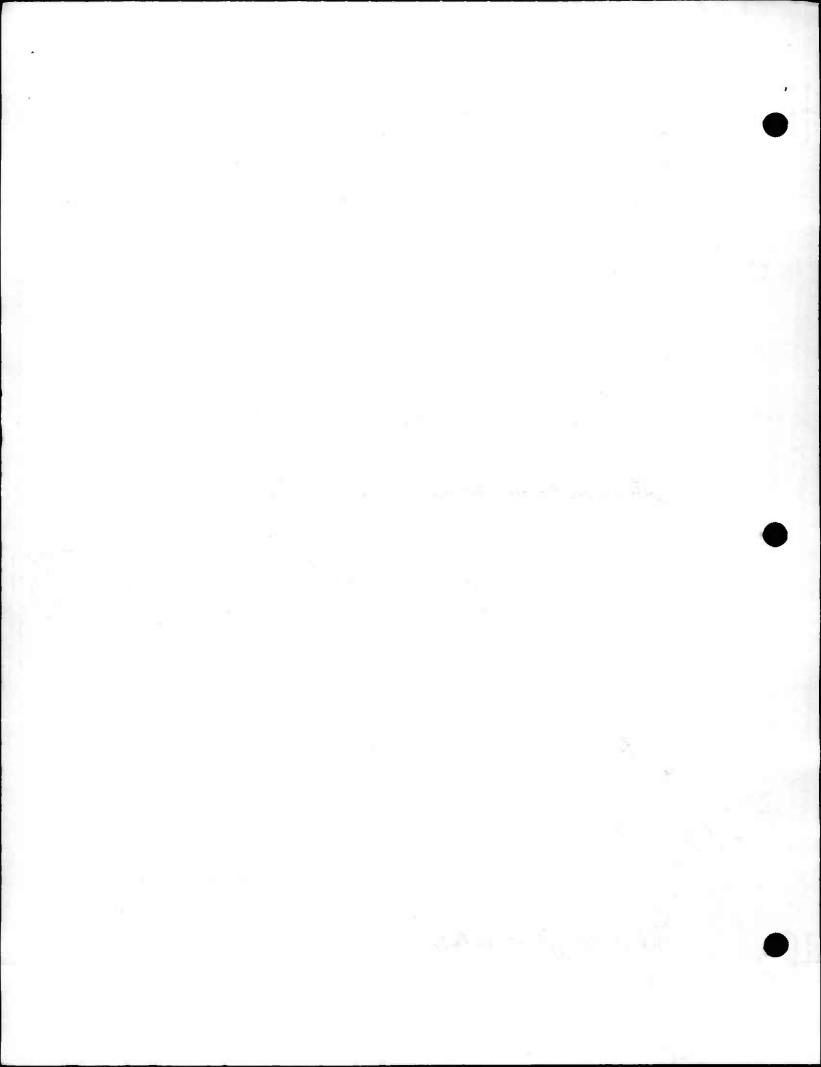


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lage 6 may be retained by the hospital or attending physician.	director, page 5 should be detached for use as the burial-transit permit. Pages	er must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or att	as been signed by the attending physician and completely filled in by the funeral d	be med within 12 indus aret deadh with the plate begin of health and Mehilla hydrene prior to borrat, chemation, or removal.  IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be no

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	-	2011	. /						2. DATE OF C	HTAS			3. TIME OF DEATH
	ADDIE		ODA	HEN	THO	RK				APRI	1 0	24	1955-	3p 11
- 8	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF B (Month, Din)	HRTH v. Ybari		a, BIRTI Count	HPLACE (State or Foreign
	214-01-3919		1 M 2 X F	104	YRS.		CALL S	HOUNS	mirt.	July 7	, 18	90		yland
- 1	9a. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CITY,	TOWN	OR LOCATI	ON OF DE	ATH		9c. COU	INTY OF C	PEATH 1
DIMECTOR	Edenwald	POPUL				To	owsc	n				Ba1	timo	re County
3	10a. STATE	10b. COUNTY	,		10c, CI1	Y, TOWN O	R LOCA	TION				-		10d. INSIDE CITY
5	Maryland	Balt	imore Co.			Tows	n n							LIMITS?
AL	10e. STREET AND NUMBER	Dare	IMOTE CO.			10030	_	r. ZIP COD	E			10a. CIT	IZEN OF	WHAT COUNTRY?
Ž	800 South	erlv R	d.					212	86			US		The second second
FUNER	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S.	ARMED	13. V	NAS DEC	ENDENT C	OF HISPAN	IC ORIGIN? (Sp	pecify Yea		14. RAC	E — American Indian,
2	1 Never Merried 2  3 Widowed 4 Divo		FORCES? 1 IF YES, GIVE W		X) NO			ecify Cube 2 NO		n, Puerto Rican	, etc.)		Spec	
		-												White
-	(Specify only	EDENT'S EDU	completed)	18a.	(Give kind of life. Do NOT u	Work done of	CUPATH furing mo	ON ost of working	ng	18b. KINI	D OF BUS	INESS/IN	DUSTRY	
	Elementary/Secondary (0 unknown	<b>⊢12)</b>	College (1-4 or 5+		Cashie	-				Тол	anha	no C	ompa	27
OMPLEIED	17. FATHER'S NAME (First, M	iddle, Last)			Jasinic			10 MOT	MED'S NAI	ME (First, Middle			ошра	II y
- 11	George W.	Henth	orn							ne Bul				
	19s. INFORMANT'S NAME (7)				19b. MAILING	ADDRESS	(Street i			loute Number, C		·	n Code)	
2	Mrs. Doris H	Rawlin	gs		1055	W. J	oppa	a Roa	d T	owson,		212		
	20a. METHOD OF DISPOSITI		nual from State	20b. PLA	CEANDDATE	OF DISPOSI	TION (Na	ime of		DATE	20c. LO	CATION —	City or To	own, State
	4 Donation 8 Other	(Specify)		Loud	on Par					4/27	Bai	ltimo	ore,	MD
Ì	21. SIGNATURE OF FUNERAL	L SERVICE LIC	ENSEE			22. P	NAME A	NO ADDRES	SS OF FAC	unera]	l D4.	no o t	240	Tes
	Steph	en 11	Jany	Sins						Rd. Ra				
	23. PART I. Enter the di	seeaes, or o	omplications that	ceused tha	death. Do	not anter	tha mo	de of dyl	ing, such	aa cardlec	or respli	ratory an	reet,	Approximate
1	IMMEDIATE CAUSE (Fin		List only one caus	se on each i	ine.		22	1	ſ		11			Onset and Death
	disease or condition reaulting in death)	<b>→</b>	. (	tre	iest	has	1	Da.	1	- Con	110	re		76
			DUE TO	OR AS A GON	SKOUENCE O	n /	7	L	V	//	1		1 -	770
5	Sequentially list conditi	one.		ATW	mp.	zel	ens	là		"hen	-1	-0	hose	1041
CALICIA	if any, leading to immediates. Enter UNDERLY		DUE TO	A SA COR	sequende o	/	V		10-1	mi	-			104
	CAUSE (Disease or injuthat initieted events		DULTO	OR AS A CON	SEQUENCE O	2000	m	a		110	u	ney		1 / 1
ē	resulting in death) LAS	T.	t							0				1
	PART II. Other significa	et condition	t contribution to	donth had a									_	
\$ <b> </b>	Train in Ginn agrinica	- Condition	s communing to	Deleth Dut no	resulting	in the uni	dertysn	g cause g	given in F	Part I. 24s.	WAS AN A		246	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
	-									10	YES 2	7.90		OF DEATH?
	-									_				T YES 2 NO
	25. WAS CASE REFERRED TO	MEDICAL					24 29	ACE OF D	E ATH COL	cit only one)				
3	I YES 2 AO		HOSPITAL:	ER/Outpatient	3 [] DOA	OTHER 4 K Num	i .	e-fore-rection coal sector	-		TOP 2			
	27. MANNER OF DEATH		28s. DATE OF	NJURY	296. TIM	E,Or T	28c. INJ	URY AT	ansence t	28d, DESCRIB		LIURY OC	CURED	
		Pending Investigation	(Month, De	100	100	M		RK7	NO					
	3 Suicide 6 C	Could not be	28s, PLACE OF building, e	INJURY At	home, farm, r	street, facto	ry, offic			201, LOCATION City or Tow	(Street a	nd Number	or Hurst F	loute Number,
ı	4   Homicide c	letermined	200000	2.550.59						ting to the	ent, poemey.			
1	CONCE ON 1 CERT	FYING PHYSIC	CIAN: To the best of r	my knowledge,	death occurr	ed at the tir	ne, date	and place.	and due t	to the cause(s)	and man	ner an stat	ed.	
	ann) Mich	CAL EXAMINE	R: On the besis of sa	amination and/	or investigation	m, in my op	ilnion, d	neth occur	ed at the 1	lime, date and p	place, and	due to th	le Couse(x	) and manner so stated.
ı	295. SIGNATURE AND TITLE	OF CENTIFIER	(		./			29c LICE	NSE NUM	HH	. 1	29d, DAT	E SIGNED	(Month, Day, Year)
		1/		~ /	you	cian		1)	29	1/09	65	•	4/9	4/95
	30. NAME AND ADDRESS OF	PERSON WHO	TOMPLETED CAUS	E OF DEATH (I	TEM 2/ (Type,	Print)	-11		16	2. 7%	6	1	10	11
	31. DATE FILED (Month, Day,	1/WO	1) - 17	1000	16	)	_ / {	0 /	V	+ con	1/2	1	13	nto.
	APR 2 8 19	95 4	32. BEĞISTRAF	I'S SIGNATURE	Z									



BALTIMORE, MARYLAND 21215	ath certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or after
MAR	retained
ORE,	6 may be
TIM	Page
BAL	after death
_	hours
90	within 24
( 687	executed
6	2
, P.O. BOX 68760	certificate
П	ath

U. Prakash, M.D.

APR 2 8 1995

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH HUGH HUDNELL 93 4 25 4. SOCIAL SECURITY NUMBER 8. BIRTHPLACE (State or Foreign 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH
(Month, Day, Year)
April 26, IF UNDER 1 YEAR 7-09-87 84 1 X M 2 - F DAYS HOURS permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and numb 9b. CITY, TOWNLOR LOCATION OF DEATH Sc. COUNTY OF DEATH Veteran DIRECTOR tospita OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10b. COUNTY 10d. INSIDE CITY Ito 1 YES 2 NO FUNERAL 10a, STREET AND NUMBER 10f. ZIP CODE WHAT COUNTRY? 10a. CITIZEN OF 2/2/6 4012 arliste ve the burial-transit ding physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indien, If yes, specify Cuban, Mexican, Pr 1 YES 2 NO Specify: 1 Never Merried 2 Marri Black ВҮ 3 Widowed 4 Divorced Specify: 38 ETED 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY use College (1-4 or 5+) Š ndary (0-12) abover COMPL detached -Ompan remica Injury, or other traumatic event, the medical examiner must be notified at once. 17. EATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle tudna varles page 5 should be lle BE ORMANT'S NAME (Type/Print) Gly or Town, State, Zip Code), Balto, Md 2 homas Jackson 5305 Ave Wesley 21207 20s. METHOD OF DISPOSITION

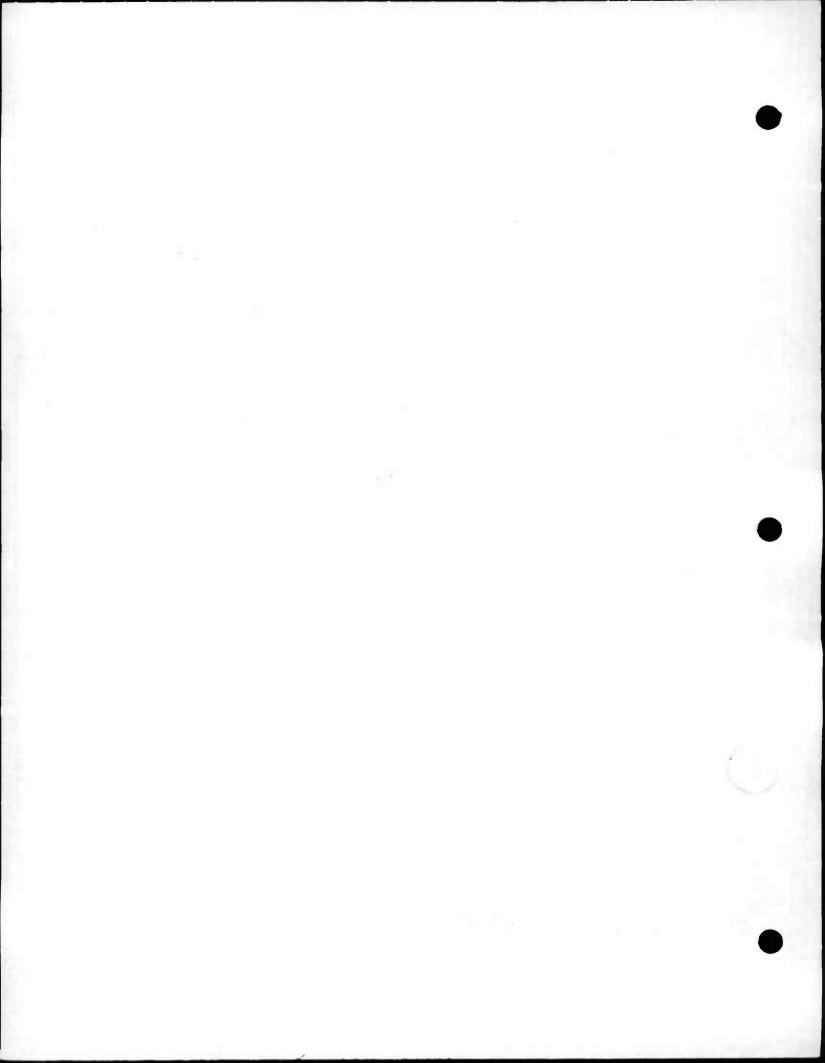
1) Burlat 2 Cremetton 3 Removal from State
4 Donation 5 Other (Specify) 206. POACE AND DATE OF DISPOSITION (No 20c-LOCATION rysician and completely filled in by the funeral director, prior to burial, cremation, or removal. FUNERAL SERVICE LICENSEF 22. NAME AND ADDRESS OF FACILITY
March + + + - 1 4300 bast 23. PART I. Enter the diseases, shock, or heart tal , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ura. List only one cause on each line. **Approximata** Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition Cardiomyopathy resulting in death) DUE TO (OR AS A CONSEQUENCE OF) Amyloidosis CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE DF): If any, leading to immediate ificate has been signed by the attending physician I State Dept. of Health and Mental Hygiene prior to Congestive Heart Failure cause. Entar UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST Amal Fibrillation/Flutter ON OF VITAL RECORDS. SMAN: The law requires that the de PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any 1 U YES 2 NO 1 - YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Item EXAMINER? 1 YES 2 ND OTHER Inpetiant 2 - ER/Outpetient 3 - DOA ne 5 🗆 Residence 8 🗆 Other (Specify) ò 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Netural ВУ 1 YES 2 NO 2 Accider
3 Suicide Accident 28e. PLACE OF INJURY — At homa, farm, street, factory, office building, stc. (Specify) COMPLETED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 23 DIRECT HOSPITAL OR ALT Item 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my k TO THE FUNERAL (
be filed within 72 h
IMPORTANT: If II 2 MEDICAL EXAMINER: On the 296. SIGNATURE AND TITLE OF CERTAFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) U. Punkash, M.D. P08626 4/25/95 2 2 3 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ox.

10 S. Greene St.

Jalia 20 CESTER RECORDS

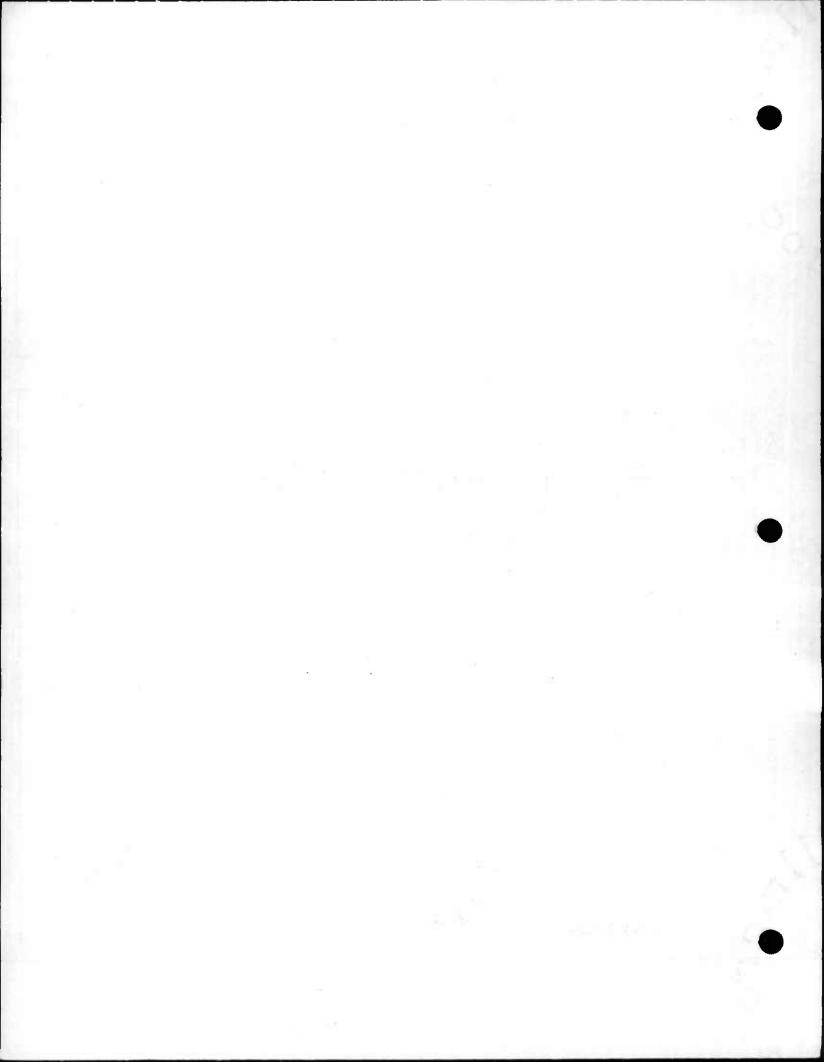
Baltimore, MD

21201



BALLIMORE, MARITAND ZIZIS-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	lied in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should 1, or removal.	e medical examiner must be notified at once.	
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	

	1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH DA		3. TIME OF DEATH
	ALBERTA HAL					4 26	199	
	4. SOCIAL SECURITY NUMBER 242-32-4903	1 M 2 X F	(In yrs. last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 4/17/23	C	INTHPLACE (State or Foreign ountry)  EW YORK
DIRECTOR	90. FACILITY NAME (If not institution, give si 509 N. EDGEWO RESIDENCE OF DECEDENT		res.)	BALTII		EATH	9c. COUNTY	n/a
EC	10a. STATE 10b. COUNTY	,	10c. CITY	TOWN OR LOCATION	ON			10d. INSIDE CITY
	MARYLAND  10e. STREET AND NUMBER	n/a	В	ALTIMO	RE ZIP CODE			1 X YES 2 NO
FUNERAL	509 N. EDGEWOO	D STREET		101.	21229			OF WHAT COUNTRY?
S	11. MARITAL STATUS	12. WAS DECEDENT EVER I		13. WAS DECE	NDENT OF HISPAI	VIC ORIGIN? (Specify Yes	or No— 14, 1	RACE — American Indian,
ВУ	1 Never Merried 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES			city Cuben, Mexics 2 XNO Specif	n, Puerto Rican, atc.)		Black, White, etc.  Specify: Black
6	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECEDENT'S U	JSUAL OCCUPATION	N Lof working	18b. KIND OF BUS	INESS/INDUSTR	PY Y
COMPLETED	Elementary/Secondary (0-12) 12th	College (1-4 or 5+)		ork done during most retired.) g Assis		Hos	pital	
SON	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Maiden :	Surname)	
BE	George Sessom	s, Sr.				rta Batts		
5	198. INFORMANT'S NAME (Type/Print)  Richard Hall					Route Number, City or Town		21229
	20a. METHOD OF DISPOSITION 1 Ramal 2 Cremation 3 Rama	oval from Stata cen	o. PLACE AND DATE Of	F DISPOSITION (Namer place)	ne of	DATE 20c. LOC	CATION — City of	or Town, State
	4 Donation G Other (Specify)		King Mem		Park S		dalls	town, MD
	* JOSEPI I	() k)	18-81	LERO	Y O. DY	ETT & SO		ERAL HOME nue 21207
	23. PART I Enter the diseases, or a	omplications that cause	the death. Do no	ot enter the mod	a of dying, suc	h aa cardiac or respir	atory arreat,	Approximata
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	CA	NCEP		FC	OLON		Interval Between Onset and Death
_		DUE TO (OR AS A	CONSEQUENCE OF)	;				
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF)	:				
2	CAUSE (Disease or injury							
Ē	that initiated events resulting in death) LAST	DUE TO (OR AS )	A CONSEQUENCE OF)	:				
MEDICAL	PART II. Other significant conditions	contributing to death b	out not resulting in	the underlying	cause given in	Part I. 24a. WAS AN / PERFORI		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ED		) ITIJE	TBS M	ELDI	145	1 YES 2	NO	OF DEATH?
Σ.	DID TOBACCO USE CONTR	PIRLITE TO CAUSE O	NE DEATH VEG		LINICEDTAIN			1 YES 2 AO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	31 3	26. PLACE OF DEATH		UNCERIAII	10]		
Sic	EXAMINER?  1 YES 2 THO	HOSPITAL: 1   Inpatient 2   ER/Outp		OTHER:	5 Residence	8 Other (Specify)		
F	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c, INJUI	RY AT	28d. DESCRIBE HOW IN	JURY OCCURE	0
B	1 Natural 5 Pending 2 Accident Investigation				S 2 NO			
TEO	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	' — At home, larm, ati cify)	reet, factory, office		28f. LOCATION (Street ar City or Town, State)	nd Number or Ru	rel Route Number,
COMPLETE		R: On the basis of axamination						
	296. SIGNATURE AND TITLE OF CERTIFIER		. 1		29c. LICENSE NUM		29d. DATE SIG	4/15/11/2
O BE		K TAM	h	1.	1	1516	D 1//	12 6198
	7	1. 1213			10	0010		20/10
2	30. NAME AND ADDRESS OF PERSON WHO  31. DATE FILED (Month, Day, Year)  APR 2 8 1995	COMPLETED CAUSE OF DE	ATH (ITEM 27) (7/00, F	432	PARK	Heights	Ave	21215



ITEMS: 23 PART I, 27, PER MED FILM 6-724 6/5/95 t.t

95 13068

TO THE HBSP IN. Thinks PHYSICIAN: The law requires that the death certificate be executed within the flower death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

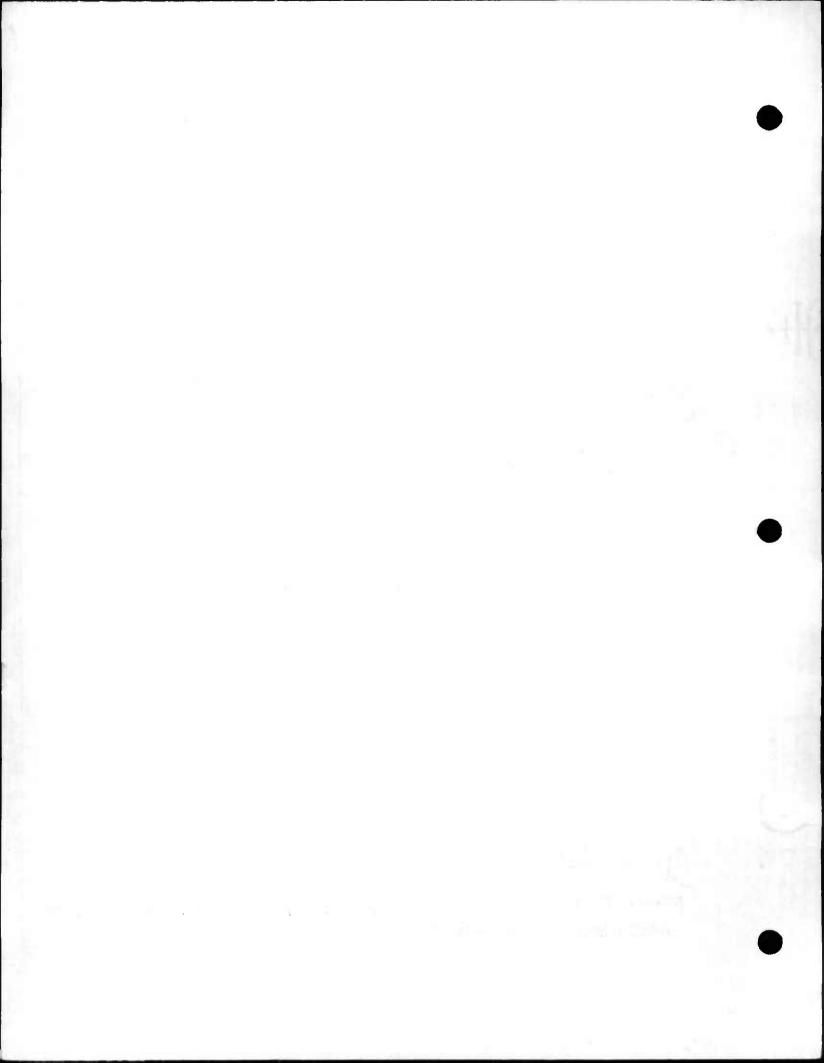
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

blh

	1 - STATE REGISTRAR	STATE UF W	IARYLAND / D CEF				DEAT		IENTAL	REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE O	F DEATH			3. TIME OF DEATH
	Floyd	Frank	lin Ha	ans	en	IV			Apr	il 2	<b>4</b> 19	95	1130 M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lest bit	irthday)	IF UNDER	t YEAR	IF UNDER	24 HRS.	7. DATE Of	BIRTH		& BIRTH	PLACE (State or Foreign
	094-82-2636	N 2 □ F	1	YRS.	EONTHS.	UATS	HOURS		Jun.	24,1	993	Ger	many
œ	9e. FACILITY NAME (If not institution, give str	reet and number)			9b. CITY	TOWN O	R LOCATIO	ON OF DEA	TH		9c. COU	NTY OF D	EATH
5	Kimbrough Army	/ Hospi	tal		F	t. N	Mead	e			Ann	e A	rundel
EC	10e. STATE 10b. COUNTY			l0c. CIT	y, town o	OR LOCAT	ION					Т	10d. INSIDE CITY
DIRECTOR	MD Anne	Arunde	T ]	Ft.	Me	ade							LIMITS?
FUNERAL	100. STREET AND NUMBER						ZIP CODE	-					THAT COUNTRY?
NEF	1615B Forrest A						2075					JSA	
BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	TEVER IN U.S. ARME	0		If yes, spe	ENDENT O	F HISPANIC n, Maxican, Specify:	C ORIGIN? , Puarto Ric	(Specify Yae en, etc.)	or No—	14. RACE Black Specif	- American Indian, White, etc.
딢	15. DECEDENT'S EDUC (Specify only highest grade of		16a. DECEE	DENT'S	USUAL O	CCUPATIO	N st of working		16b. K	IND OF BUS	SINESS/INC	DUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 +	) life. Do	NOT us	se retired.)	ouring mo:	st or worun	9		n/			
M	n/a 17. FATHER'S NAME (First, Middle, Last)	n/a	- 1	n/a			The last train						
	Floyd F. Hanser	o TTT							e (First, Mid a Le	Idle, Meiden	Sumame)		
BE	19e. INFORMANT'S NAME (Type/Print)		19b. M	IAILING	ADDRESS	S (Street e				City or Town	n. State Zir	Code)	
임	Floyd F. Hanser	n III											MD 20755
	20e. METHOD OF DISPOSITION 1) Burial 2 □ Cremetion 3 □ Remo	wel from State	20b. PLACE AND				me of		DATE	20c. LO	CATION -	City or Tox	wn, State
	4 Donation 5 Other (Specify)		New Le	eba	non	Cei				L	ebar	on,	CT
	21. SIGNATURE OF FUNERAL SERVICE LICE	M			H	ard	esty		nera	l Ho			
	23. PART I. Enter the diseases, or co	omplicatione that	caused the deeth	n. Do n									Approximate
	ahock, or heart fellure. L IMMEDIATE CAUSE (Final disease or condition resulting in death)	NO ANAT	OMIC CAUSE	OF [	DEATH								Interval Between Onset and Death
z	urece iracias ir are				1								į
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (	OR AS A CONSEQUE	NCE OF	F):			1					
5	CAUSE (Disease or injury that initiated events	DUE TO	OR AS A CONSEQUE	NCE OF	D.								
E	resulting in deeth) LAST		OTTO K GOTTOEOGE	.1101. 01	,.								İ
DICAL	PART II. Other significent conditions	contributing to	death but not reeu	ilting i	n the un	derlying	ceuse g	iven in Pa	art I. 2	4a. WAS AN		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
EDIC				-					_   1	YES 2	□ NO		COMPLETION DF CAUSE OF DEATH?
Σ	DID TODA GOO HOUSE								_				1 TYES 2 NO
AN	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL	IBUIE 10 CAL					UNC	ERTAIN					
PHYSICIAN:	EXAMINER?	HOSPITAL:	26. PLACE O		OTHER	₹:							
¥	27. MANNER OF DEATH	28a, DATE OF I	ER/Outpatient 3 N	Bb. TIM		28c. INJL		-	Other (S	Specify)	I II IIIV OC	NIDED.	
	1 XX Natural 5 Pending	(Month, Da	y, Year)	INJ	URY	WOI			edd. DEGCI	MDL HOW IN	WONI OCC	JONED	
D BY	2 Accident Investigation 3 Suicide 6 Could not be	28s. PLACE OF	INJURY — At home,	form, s	street, fact	ory, office		2	28f. LOCATI	ON (Street e	nd Number	or Rural Ro	oute Number,
Ë	4 Homicide determined	bonding, a	itc. (Specify)						City or	Town, State)			
COMPLETE	29e. CERTIFIER (Check only 1 CERTIFYING PHYSIC	IAN: To the best of I	my knowledge, death	occurre	d at the ti	me, date	end place,	and due to	the cause	(s) and man	ner es atat	ed.	
8	One) 2 MEDICAL EXAMINER												end manner as stated.
BE	AL SIGNATURE AND TITLE OF CENTIMEN	> 001	1				29c. LICE	NSE NUMB	ER		29d. DAT	E SIGNED	(Month, Day, Year)
10 B	MINNE	ANY >	I N				_0 0	M	F		► A ~	ril	25 1005
-	MAG IN E- CO	COMPLETED CAUSE	DAY OF ATH (ITEM 27										
	31. DATE FILED (Morith, Day, Year)	32, REGISTRAI	R'S SIGNATURE	_Pe	enn	Str	eet,	Ba	ltim	ore.	Maı	cyla	nd 21201
	APR 2 8 1995	32 REGISTRAF	Mardall										



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALLIMORE, MARYLAND 21215-0020	BALLIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	PHYSICIAN: The law requires that the death certificate be executed with crours after death. Fage 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funer be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	his certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
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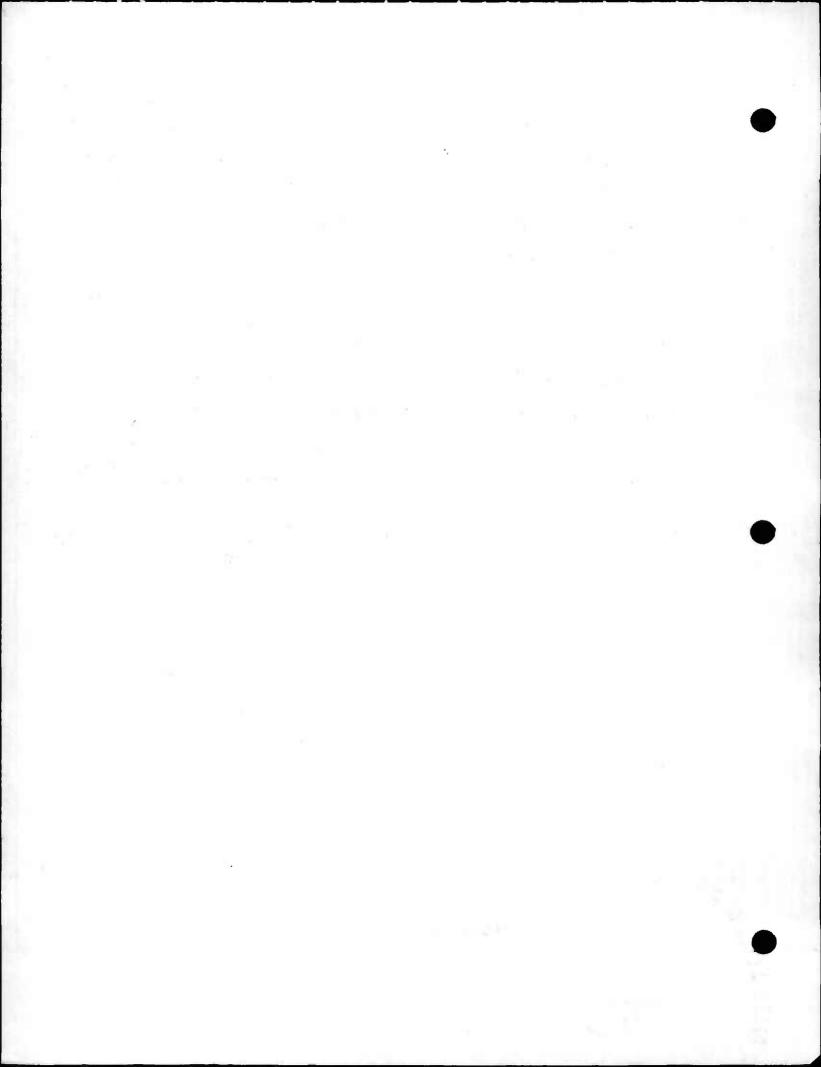
P

21. DATE FILED (MONTH, Day, Voer) APR 2 8 1995

				70	13003
	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEAL CERTIFICATE OF DE		AL HYGIENE REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, Last)  MARTHA M. HICKMON	2. DAT	E OF DEATN		year 4 A . M
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) F UNDER 1 YEAR F U 216-05-1685 1 \( \to \) M 2 \( \text{X} \) F 82 YRS. MONTHS DAYS HOU	MDER 24 HRS. 7. DAT	E OF BIRTH  oth, Day, Year)  2, 19	8	BIRTHPLACE (State or Foreign Country) Boring Md.
OR	9a. FACILITY NAME (If not institution, give street and number)  1013 Cockeysmill Road  Reiste		, 1	9c. COUNT	y of DEATN Baltimore
FUNERAL DIRECTOR	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Reisters	stown			10d. INSIDE CITY LIMITS?  1 YES 2 NO
ERAL E	100. STREET AND NUMBER 1013 Cockeysmill Road	CODE 211	136	10g. CITIZE	N OF WHAT COUNTRY?
В		ENT OF NISPANIC ORIG Cuban, Maxicon, Puart JNO Specify:		or No- 1	6. RACE — American Indian, Black, White, atc. Specify: White
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  High School  18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of white. Do NOT use retired.)  HOUSEWIFE	working	66. KIND OF BUS		STRY
BE CON	17. FATHER'S NAME (First, Middle, Last)  Clarence Merkel	MOTHER'S NAME (First			
T0	Mrs. Nancy H. Posner  190. INFORMANT'S NAME (Type/Print)  4123 Worthington				vn, Md. 21136
	20a METHOD OF DISPOSITION 1 \( \text{N Burlei} \) 2 \( \text{Cremation} \) 3 \( \text{R amoval from State} \) 4 \( \text{Donation} \) 5 \( \text{Other (Specify)} \)  20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Reisterstown Method	1			y or Town, Stata
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	opress of Facility uneral Hon	1182	24 Rei	isterstown Rd.
(	21. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each lins.  IMMEDIATE CAUSE (Final alless)  The control of the cause of condition as a cause or condition as a cause or condition as a cause or condition as a cause of cause			etory arres	ot, Approximate interval Batween Orisst and Dasth
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF):    Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST				
PHYSICIAN: MEDICAL	PART ii. Other significant conditions contributing to death but not resulting in the underlying cat	use givan in Part I.	24s. WAS AN A PERFORI	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 24 NO
AN: A	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 25. WAS CASE REFERRED TO MEDICAL	OF DEATH (Check only	9001		NA
IYSIC	EXAMINER?  1	Raaldenca 8 - Ot	her (Specify)		
B	1 Netural 5 Pending investigation 2 Accident 8 Could not be detarmined detarmined	2 NO 281. LC	DCATION (Street as by or Town, State)		Rural Route Number,
COMPLETED	29e. CERTIFIER (Check only one)  29 MEDICAL EXAMINER: On the beet of my knowledge, death occurred at the time, data and money one)				
TO BE CO	and a second supplier of the second supplier	LICENSE NUMBER	6		ceuse(a) and manner as stated.

Boltmore, and 2/20

#718



1 - FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MARIE HENTZ SCHEL ANNA APRIL 24 5:00 AM 1995 7. DATE OF BIRTH
(Month, Day, Year)
Oct. 23,1903 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 218-52-3137 1 M 2 X F Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Charlestown Care Center Baltimore Baltimore RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Baltimore 1 TYES 2 X NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP COOF 10g. CITIZEN OF WHAT COUNTRY? 9009 Perring Park Road U.S.A. director, page 5 should be detached for use as the burial-transit 21234 the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify, Cuban, Maxican, Puerto Rican, atc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, Whits, stc. **BALTIMORE, MARYLAND 21215-0020** 1 Never Married 2 Married specify: White BY 3 🕅 Widowed 4 🗌 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEOENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INOUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) 8th grade Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Page 6 may be retained by I Henry (First Name Unknown) 7 Luerssen Lieber BE notified 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Elsa Zeiler (daughter) 806 Fairway Drive, Baltimore, MD pe 20a, METHOD OF DISPOSITION
1 X Burist 2 Cremation 3 4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must Parkwood Cemetery 4/27 Baltimore, Maryland examiner 21. SIGNATUI OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Schimuner Funeral Homes, Inc. funeral 9705 Belair Rd., Baltimore, MD the 1 21236 medical 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tallure. List only one cause on each line. filled in by Approximate Interval Between 6 IMMEDIATE CAUSE (Final **Onset and Death** the disease or condition and completely fi to burial, cremation Atheroscherotic Cardiovascular desease ears resulting in deeth) event, RECORDS, P.O. BOX 68760 OUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate cause. Enter UNDERLYING the attending physician a prior CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO signed by the COMPLETION OF CAUSE 1 - YES 2 1 NO 1 YES 2 NO has been Dept. of H PHYSICIAN: DIVISION OF VITAL 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h **EXAMINER?** HOSPITAL: 1 TES 2 100 1 Inpatient 2 ER/Outpatient 3 DOA ne 5 🗆 Residence 8 🗆 Other (Specify) 5 the 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) this c 28b. TIME OF 28c. INJURY AT WORK? 28d. OEŞCRIBE HOW INJURY OCCURED is marked, 1 Natural 5 Pending Investigation 1 YES 2 NO BY After HOSPITAL OR ATTENDING 2 Accident 28s. PLACE OF INJURY — At home, farm, atreat, tactory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town (State) DIRECTOR: A hours after d item 28 is COMPLETED 8 Could not be 4 Homicide 29s. CERTIFIER
(Chack only

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and dus to the cause(s) and manner as attated. TO THE HOSPITAL OF TO THE FUNERAL D DE filed within 72 ho 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Pairice Dorney M. D 4/24/9 047020 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DORNEY PATRICIA MADEN CHOICE LANE

31. DATE FILEO (Month, Day, Year)

APR 2 8 1995

32. REGISTRARY SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

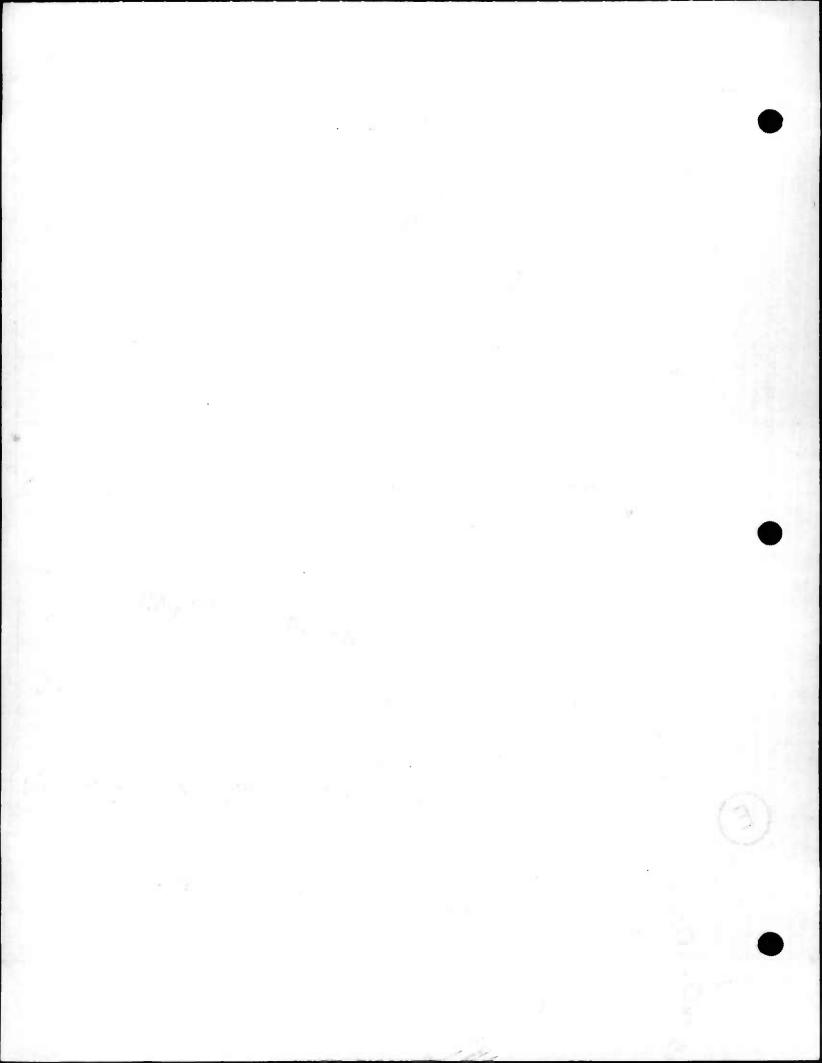
The March of the Bear St. and The Bear St.

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1	DIREC	Anima
TO THE HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death	TO THE PUNETW, DIRECTED ALL After this certificate has been signed by the attending physician and completely filled in by the fune	withten 35
岩	뿔	find
B	P	2

		1 - STATE REGISTRAR	STATE OF MARYLAI	ND / DEPAR Certif	TMENT OF H	IEALTH AND I	MENTAL HYGIEN REG. NO	_	
		1. DECEDENT'S NAME (First, Middle, Last)	~				2. DATE OF DEATH		3. TIME OF DEATH
		DOROTHY	PONEZ				4 2		5 5:05 g m
		0 0>0		yrs. lest birthday)	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	200	BIRTHPLACE (State or Foreign Country)
		9e. FACILITY NAME (If not institution, give stree		YRS.			July 15,1	425	Marylana
	œ	MAT VENCTU C		1.10	96. CITY, TOWN C	OR LOCATION OF DE	EATH /	9c. COUNTY	OF DEATH /
	СТОВ	RESIDENCE OF DECEDENT	nachlawi He	spital	BOIT	nore,		balt	imore
	DIRE	10a. STATE 10b. COUNTY	'n	10c. CIT	, TOWN OR LOCAT	ON			10d. INSIDE CITY LIMITS?
		Maryland Ni	<u>A</u>	P	altim	ore			1 YES 2 NO
	RA	10e. STREET AND NUMBER	atom St	_	101	ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?
_	FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U	I S ADMED	12 WAS DEC	XIXIE	ORIGIN? (Specify Yes	1	SH
		1 Never Merried 2 Married		2 NO	If yes, spi	ecity Cyben, Mexica 2 NO Specify	n, Puerlo Rican, etc.)	or No-   14	Black, White, atc.
	BY	3 Widowed 4 Divorced				Z (M) NO Specify	<i>;</i> .		Specify: Black
	ETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor		(Give kind of v	OSUAL OCCUPATION OF MORE DOOR DOOR OF MORE DOOR DOOR OF MORE DOOR OF M	on st of working	16b. KIND OF BUS	SINESS/INDUS	TRY
		Elementary/Secondary (0-12)	College (1-4 or 5 +)	HAN V	10 m	Kor	Dil	nL	tomo
once.	COMPL	17. FATHER'S NAME (First, Middle, Last)		11011	101110	1/1C	1000		IOME
3		William Joh	inson			A T	ME (First, Middle, Meiden	C AT	+
notified at	BE C	194. INFORMANT'S NAME (Type/Print)	. 10011	19b. MAILING	ADDRESS (Strept a	nd Number or Rural I	Poute Number, City or Tow	n, Stata, Zio Co	ide)
not	일	Clarence Ja	ones	2201	1 Ashi	burto	n St. Ba	Ito.	Md 21216
st be		20e. METHOD OF DISPOSITION 1 W Burlel 2 Cremation 3 Remova	1 Imm State 20p-Pi	LACE AND DATE	F DISPOSITION (No	ma of /	DATE 200, LO	CATION - City	or Town, State
r must		4 Donation 5 Other (Specify)	G	ery cresperon or of	50h	orest	3/1/95 B	alto.	Co. Md.
mine		21. SIGNATURE OF FUNERAL SERVICE OCEN	DID.	/	T	D ADDRESS OF EA	CILITY	ner	al Hama
ехэ		Mech	d. Kul	11	205et	ZVIT NO	THE AVE	137	Ito Mc 2/2/6
medical examiner		23. PAHT A. Enter the diseases, or com	unilestions that caused to						
		## #book or beert fellure Lie	t only one cause on seel	hs death. Do n	ot enter the mod	de of dying, suci	h aa cerdiec or respi	ratory arrest	t, Approximata
5 <b>=</b> 1		IMMEDIATE CAUSE (Final	at only one causs on saci	hs death, Do n h line.	ot enter the mod	de of dylng, sucl	h aa cerdlec or respi	ratory arrest	t, Approximata interval Batween Onaat and Death
1		Shock, or neart failure. Lis	Tracheal	\$ Bron	chial 1		21	1.1	Interval Batween Onset and Death
event, the		IMMEDIATE CAUSE (Final disease or condition	Tachcal DUE TO (OR AS A C	\$ Bron	chial 1	Mucus	Plugging	y → Hy	Interval Batween Onset and Death
matic event,	NOI	IMMEDIATE CAUSE (Final disease or condition resulting in death)	DUE TO (OR AS A C	Bronouseduence of	chial 1	Mucus	21	y → Hy	Interval Batween Onset and Death
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MISSION OF VITAL RECORDS, P.O. BOX 68760	The state of the s
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*		1 - STATE OF MARY	YLAND / DEPARTM CERTIFICA	ENT OF HEALT	H AND MENTAL HY	GIENE 3. NO.	
		1. DECEDENT'S HAME (Flist, Middle, Last)  Columbus	s D. Joyn	er	2. DATE OF OE, MONTH April	25, 199	
be d		4. SOCIAL SECURITY HUMBER 5. SEX 6. AC		UNDER 1 YEAR IF UND	DER 24 HRS. 7. DATE OF BIRT	TH R BI	IRTHPLACE (State or Foreign ountry)
	~	9a. FACILITY HAME (If not institution, give street end number)	9b.	CITY, TOWN OR LOCA	TION OF DEATH	9c. COUNTY O	Md DF OEATH
	стов	Union Memorial Hospital		Baltimor	^e	N/A	
	DIRE	10a. STATE 10b. COUNTY N/A	Balti	IMORE			10d. INSIDE CITY LIMITS?  1 X YES 2 NO
	FUNERAL	100. STREET AND HUMBER 1019 Edmondson Avenue		10f. ZIP CO		10g. CITIZEH C	OF WHAT COUNTRY?
	BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried FORCES? 1 Y IF YES, GIVE WAR OF	ES 2 XHO	13. WAS DECEMBENT	OF HISPAHIC ORIGIN? (Spec ben, Mexicen, Puerto Ricen, e	offy Yee or Ho 14. R	RACE — American Indian, Black, White, etc.
	ED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S USU	AL OCCUPATION	16b. KIHD 6	OF BUSINESS/INOUSTR	Втаск
	COMPLET	Elementary/Secondary (0-12) College (1-4 or 5+)  11th grade N/A	Stude:	done during most of wor ired.) nt		glas Hig	ih School
		17. FATHER'S HAME (First, Middle, Last) Columbus Joyner		18. MC	THER'S HAME (First, Middle, A Emily Stator	Maiden Surneme)	
	TO BE	19a. IHFORMANT'S NAME (Type/Print)	19b. MAILING ADO	PRESS (Street and Numb	per or Rural Route Number, City	or Town, State, Zip Code,	)
		Emily Staton  200. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DIS	dmondson		oc. LOCATION - City o	
Page 6 direct		1 M Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Cedar Hill		42995	Arundel C	o, Md
s AL r death re fune al.		Elevenne A. Tho	mpson	4300	F/H West Wabash Aven	ue Baltin	nore, Md 21215
24 hours after filled in by the ion, or removal		23. PART i. Enter the diseases, or complications that cause speck, or heart failure. List only one cause or iMMEDIATE CAUSE (Final disease or condition	esch line.		lying, auch se cardiac or	reapiratory arrest,	Approximata interval Between Onset and Death
ecuted within and completely burial, cremat atic event, i		resulting in death)	E AULMAN S A GONSEQUENCE OFF	ory eml	roling		1 how
execute and ca to buria	LION	Sequentisity list conditions, if any, lesding to immediate	OUE TO (OH AS A CONSCIONARY OF): 3 WEE				3 weeks
P phy ne p	RTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events  OUE TO (OR A)	POUL	OCME			
T E E O	CERT	resulting in death) LAST		nc.A	<b>P</b> BONED	00.	
र इंके के	SAL	PART II. Other significant conditions contributing to death		a undarlying cause	PI	ERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
law requires that as been signed begt. of Health ar 23 shows any	MEDI					ES 2 W NO	OF DEATH?
as begin	IAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE 25. WAS CASE REFERREO TO MEDICAL	OF DEATH YES [		CERTAIN 🗆		
NOING PHYSICIAN: The Rater this certificate he death with the State is marked, or item	PHYSICI	EXAMINER?  1	Putpetient 3 DOA 4 D	HER: Hursing Home 5   28c, INJURY AT	Residence 8 - Other (Specif		
	ВУ РІ	1 Hetural 5 Pending (Month, Day, Year 2 Accident Investigation 3-3/-9	1748	M 1 YES 2	THO FELL F	HOW INJURY OCCURED	BINE.
N A S	ED	3 Suicide 8 Could not be determined 28e. PLACE OF INJU building, etc. (S	Specify) At home, lerm, street			Sycoland Nymbor & Rill	or D. 212
	COMPLET	29e. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my kn one)  2 MEDICAL EXAMINER: On the basic of examina			ce, end due to the cause(e) en	nd manner se stated.	se(e) end manner se stated,
TO THE HO TO THE FL TO Fled IN	BE C	296. SIGNATURE AND TITLE OF CERTIFIER			CENSE NUMBER	VIII.//	NEO (Month, Day, Year)
223	2	30. HAME AND ADDRESS OF DERSON WHO COMPLETED CAUSE OF	DEATH (ITEM 27) (Type, Print	) 11	16328	Cip	il 26, 1995
5		31. DATE FILED (Morning OFO EO) JULIA MANAGESTRAN'S SI	GHATURE KENAD	HOSPIT	ul 2201	Argonne	Or Paring
		WAKS & 1222 O.					



rSICIAN: The law requires that the death certificate be executed with hours after death, Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should inthe State Dept, of Health and Mental Hyslene prior to burial, cremation, or removal.	ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
YSICIAN: The law requires that the	s certificate has been signed by the the State Dept, of Health and N	ed, or item 23 shows any inj
ITENDING PH	TOP After this	Ze is marke
PITAL OR A	72,700.57	É
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5	F 5	=

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF H		MENTAL	HYGIENE
CERTIFICATE OF	DEATH		REG. NO.

	1 - FOR STATE REGISTRAR	STA	TE OF MARY	LAND / DEPA CERTII	RTMENT OF	HEALTH AND	MENTAL HYGIEN	E			
	1. DECEPENT'S NAME (First, M Catherine Lo	ouise Joh	nson				2. DATE OF DEATH MONTH DA	<u> </u>	3. TIME OF DEATH 7: 36 Pm		
	4. SOCIAL SECURITY NUMBER 219-26-846	5. SEX	6. AGE	56 YRS.	MONTHS DAYS		7. DATE OF BIRTH	a, Bir	Maryland		
DIRECTOR	9s. FACILITY NAME (# not instituted in the control of the control	_	numper)		96. CITY, TOWN OR LOCATION OF DEATH Balto City			9c. COUNTY OF DEATH N/A			
EC	RESIDENCE OF DECE	IOB. COUNTY		10c. C	ITY, TOWN OR LOC	ATION			10d. INSIDE CITY		
	Md .	N/	/A		Balt	imore C	ity	LIMITS?			
FUNERAL	2419 West	Coldspi	ing La	ne		212	15		F WHAT COUNTRY?		
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Divorce	S DECEDENT EVER RCES? 1 1 YES (ES, GIVE WAR OR	NO 2 NO	If yes,	CENDENT OF HISPA pecify Cuben, Mexic S NO Speci	NIC ORIGIN? (Specify Yes an, Puerto Ricen, etc.) fy:	BI	ACE — American Indian, lack, White, atc.			
COMPLETED	15. DECED (Specify only hi Elementary/Secondary (0-12	DENT'S EDUCATION lighest grade complete		18s. DECEDENT' (Give kind o	S USUAL OCCUPA: I work done during i use retired.)	TION nost of working	16b. KIND OF BUS	INESS/INDUSTRY	·		
립	12th		• (1-4 or 5+) YES			perviso	r ni		eutical		
Š	17, FATHER'S NAME (First, Midd	fle, Last)	•				AME (First, Middle, Maiden :		Surical		
H	Andrew She	errill				Ma	ry Wilson	ı			
5	196. INFORMANT'S NAME (Type Isaac I. J	o/Print) Tohnson		19b. MAILIN 241	9 West	and Number or Rural Coldsp	Route Number, City or Town	Balto	o, Md 21215		
	20s. METHOD OF DISPOSITION 1 X Burisl 2 Cremation 4 Donation 5 Other (S)	3 Removal from	State 20	b. PLACE AND DATE	other place) On Fore	st Vet		Owings	Town, State		
	21. SIGNAPORE OF NUNERAL S	SERVICE LINENSEN		0	22. NAME	AND ADDRESS OF F	CLITY CORLO	Funces	al Service		
	10	X 3	· ( 2/2	el	550	2 Winne	r Ave Bal	to, Mo	1. 21215		
	23. PART I Enter the dise shock, or hea	rases, or camplice or failure List only	etions that cause y one cause on	ed the deeth. Do	not enter the m	ode of dying, aud	h as cardlec or respli	ratory arrest,	Approximate Interval Between		
	IMMEDIATE CAUSE (Finel disease or condition reaulting in death)		Cardo	ac v	Asshutt	imia			Onset and Death		
	reasiting in deating	•	DUE TO (OR AS	A CONSEQUENCE.	4 /110	11/5/	etus Chai	MARS	24 hours		
TIO	Sequentielly list condition if any, leading to immedia	ete T	DUE TO (OR AS	A CONSEQUENCE	OF): 2	1 Tal	Tubo!	7	2/ 1/		
2	CAUSE (Disesse or Injury		Ena Si	A CONSEQUENCE	Kena	Tui.	ure !		6 Noning		
CERTIFICATION	that initiated events resulting in death) LAST	d	Diabes	Los M	MULLITIS			>10 yrs			
N/	PART II Other significent	conditions contri	buting to deeth	nal sulting	lin the underlyl	ng ceuse given in	Part I. 24a. WAS AN / PERFORI	WED?	4b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
CIAN: MEDIC	HYPERTENIS	1001					′		1 TYES 2 NO		
ž	DID/POBACCO USE		TO CAUSE (				N 🗆				
	25. WAS CASE REFERRED TO N EXAMINER?	НОЕР	PITAL:		OTHER:	)					
PHYS	1 YES 2 NO		atient 2 ER/Ou	tpatient 3 DOA	7	me 5 Residence					
BY P	1 Natural 5 Per		(Month, Day, Year)		IJURY W	JURY AT ORK? YES 2 NO	28d. DESCRIBE HOW IN	JURY OCCURED			
9	3 Suicide 8 Co		28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, etc. (Specify)			281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
	29s. CERTIFIER 1 CERTIFY	YING PHYSICIAN: To	the best of my kno	wledge death occur	rad at the time de	a and place, and dur	to the cause(s) and man				
									e(s) and menner as stated.		
O BE CO		2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as attated.  29b. SIGNATURE AND TITLE OF CERTIFIER  29c. LICENSE NUMBER  27 243 8946 - F22  29d. DATE SIGNED (Month, Day, Year)  ADV 104 1045									
2	JACQ UE	ERSON WHO COMPLETE	ROY CE	EATH (ITEM 27) (Typ)	e, Print)	UMH		.,	- //		
	APR 2 8 1995	" Jalin da	REGISTRAR'S SIG	NATURE (all							

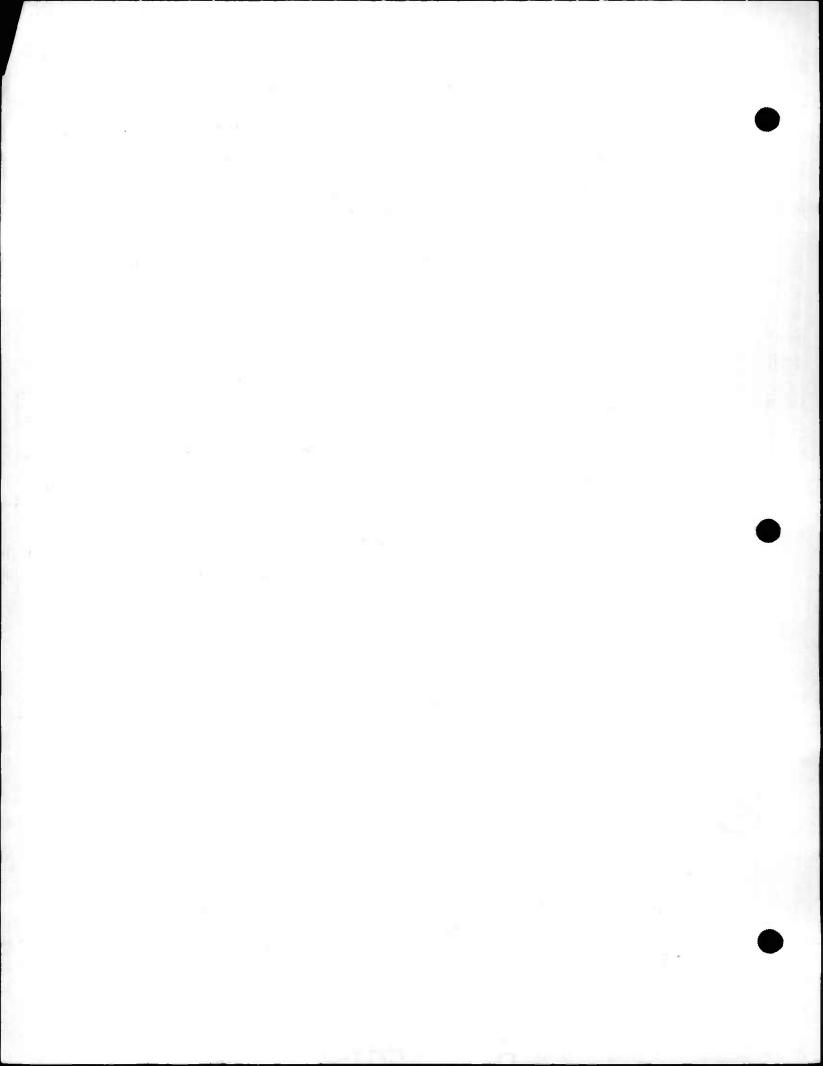
DIVISION OF VITAL RECORDS, P.O. BOX 68760, ING PHYSICIAN: The

<b>ega</b>	S	
60	3	
THE PRICIANS THE LAW REQUIRES THAT THE DEATH CENTINGAIE DE EXECUTED WITHIN 24 HOURS ARET DEATH. PAGE D MAY DE RETA	Im this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 st	
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	10	In the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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TO THE HOSPITATO THE FUNER DE FILE WITHIN IMPORTANT.

marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF	HEALTH AND F DEATH	MENTAL HYGII					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	DAY		3. TIME OF DEATH		
	WILLIAM C. KES					April	24	1995	06:40 A. M		
	4. SOCIAL SECURITY NUMBER 213-01-0039	1 XM 2   F	(In yrs. lest birthdey) 77 YRS.	IF UNDER 1 YEAR		7. DATE OF BIRTYN (Month, Day, Year) AUG. 2, 19	17	6. BIRTH Countr	PLACE (State or Foreign		
DIRECTOR	9a. FACILITY NAME (If not institution, give st ST. AGNES HOSPITA			96. CITY, TOW BALTI	OR LOCATION OF D	EATH	1	UNTY OF D	MORE CITY		
띮	RESIDENCE OF DECEDENT  10e. STATE 10b. COUNTY		10c, CIT	Y. TOWN OR LO	CATION	10d. INSIDE CITY					
	MARYLAND BALT  100. STREET AND NUMBER	IMORE		CATONSVILLE					LIMITS?		
FUNERAL	719 MAIDEN CHOICE				21228		10g. CI1	U.S.	A.		
B≼	11. MARITAL STATUS 1 Never Married 2 X Married 3 Wildowed 4 Divorced	N U.S. ARMED 2 XNO ATES	If yes,	ECENDENT OF NISPA specify Cuban, Mexic ES 2 NO Speci	NIC ORIGIN? (Specify an, Puerto Rican, etc.) fy:	Yea or No-	14. RACE Black Specifi	— Americen Indian, , White, etc. fy: WHITE			
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	CATION completed)  College (1-4 or 5+)	IIIe. Do NOT us	work done during se retired.)	TION most of working	16b. KIND OF	BUSINESS/IN	IDUSTRY			
MP	12 + 17. FATHER'S NAME (First, Middle, Last)		SALES M	IANAGER	_	CROWN,			L		
8	CLARENCE N. KESLE	p				AME (First, Middle, Maid	len Sumame)				
出	19a. INFORMANT'S NAME (Type/Print)	K	19b. MAIL ING	ADDRESS (Street		Y DODGE  Route Number, City or 1	Sauce Chate 7	Va Cardal	21228		
2	MRS. MARY C. KESL	ER							ONSVILLE, MD		
	20s. METNOD OF DISPOSITION  1	val from State 20b	PLACE AND DATE OF THE PROPERTY	OF DISPOSITION	Name of	DATE 20c.	LOCATION -	- City or To			
	21. SIGNATUILE DE FUNERAL SERVICE LICE	21. SIGNATULE OF FUNERAL SERVICE LICENSEP.  LOUDON PARK CEMETERY   4/29   BALTIMORE  22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC.									
	- Jackie	d sha	mo					n			
	23. PART I. Softer the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiec or reepiratory erreet, ehock, or heart feliure. List only one cause on each line.  4107 WILKENS AVENUE—BALTIMORE, MD 21229  Approximate interval Between										
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST    AGUSTE MIOCARDIAL INFARCTION, LEFT VENTRICLE, POSTERIOR 12-24 Hrs										
CAL	PART II. Other eignificant conditions					0.000	AN AUTOPSY ORMED?	24b.	WERE AUTOPSY FINDINGS		
MEDIC	<u>Diabetes Mellit</u> and Left Legs	us, Status P	ost Ampu	tation	s of Righ	+	2 NO		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
	DID TOBACCO USE C	ONTRIBUTE TO	CAUSE OF	DEATH	YES NO				1 X YES 2 - NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 XNO	HOSPITAL: 1 X Inpetiant 2 - ER/Outp	atlent 3 DOA	OTHER:	PLACE OF DEATH (Ch						
F	27, MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	26b. TIM	E OF 28c. I	NJURY AT YORK?	28d. DESCRIBE NOV	V INJURY OC	CURED			
BY	1 X Natural 5 Pending 2 Accident Investigation			M 1 [	YES 2 NO						
	3 Suicide 6 Could not be 4 Nomicide detarmined	28s. PLACE OF INJURY building, atc. (Spec	— At home, farm, a	street, factory, of	Nea	281. LOCATION (Stree City or Town, Sta	set and Number or Rural Route Number, ate)				
COMPLETED	29e. CERTIFIER (Check only one) 1 XCERTIFYING PHYSIC DESCRIPTION ON 1 MEDICAL EXAMINER	IAN: To the best of my knowl	edge, death occurre	ed at the ilme, do	te and place, and due	to the cause(a) end n	nanner se ste	nted.			
	296 AJGNATURE AND TATLE OF CERTIFIER	Do	3410	, opinion	1						
TO BE	30. NAME AND ADDRESS OF PERSON WHO COMPLETED PAUSE OF DEATH (ITEM 27) (Type, Print)  29c. LICENSE NUMBER  29d. DATE SIGNED (Mor								(Month, Day, Year)		
	Dr. Michael E. Pe		nes Hosp		O Caton	Ave Ralt	imore,	, Md.	21229		
	APR 2 8 1995 H	in diwater has	blall						1		



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DIVISION OF VITAL RECORDS, P.O. BOX 13146,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely these in	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or re
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IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner

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	1 - FOR STATE REGISTRAR	STATE OF MA			TMENT OF H		MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH			TIME OF DE	ATH
	Charles	Lionell	Ki1	1mar	1		Apr. 24,	1995	EAR	CA	m M
	4. SOCIAL SECURITY NUMBER	5. SEX	B. AGE (In yrs. last		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLA	ACE (State or	Foreign
	218-01-2729	1 _X M 2 □ F	78	YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) May 1, 19	~ 1111	Country)		
	9a. FACILITY NAME (If not institution, give a	Ireet and number)			9b. CITY, TOWN C	R LOCATION OF DE	ATH	9c. COUNTY	OF DEAT	Н	
FUNERAL DIRECTOR	Ivy Hall Geria	tric Cente	er		BALT	IMORE		BAL	TIMO	RE	
E	10s. STATE 10b. COUNTY	1		10c. CIT	Y, TOWN OR LOCAT	ION		104	d. INSIDE CI	īΥ	
8	MARYLAND BALT	IMORE		R	ALTIMORE				11	LIMITS?	□ NO
٦	10e. STREET AND NUMBER	LTIONE		D.		ZIP CODE		10a, CITIZER		T COUNTRY	
A		- ·					0.0				
빌	1300 Windlas					212			JSA		
교	1 Never Married 2 Married	12. WAS DECEDENTY FORCES? 1	YES 2 N	MED			NIC ORIGIN? (Specify Year, Puerto Ricen, etc.)	e or No 14.	. RACE Black, W	American In-	dien,
B	3	12/15/42-10/30/45			1 TYES	2 X NO Specif	y:		Specify:	יחידי	
	Λ	· · · · · · · · · · · · · · · · · · ·							WHI	.IL	
	15. DECEDENT'S EDU (Specify only highest grade		16a. DE	ve kind of	WORK done during mo	on at of working	16b. KIND OF BU	ISINESS/INDUS	TRY		
<b>"</b>	Elementary/Secondery (0-12)	College (1-4 or 5+)	Sive kind of work done during most of working a. Do NOT use retired.)								
COMPLETED		4	Rec	reat	irector ion cent			nicipal	Gov	ernme	nt
Ö	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First, Middle, Maider	Sumame)			
BE (	William	Henry Killman Louise Cather					rine Paul				
	19e. INFORMANT'S NAME (Type/Print)	-	198	. MAILING	ADDRESS (Street II	and Number or Rural	Route Number, City or Tox	wn, State, Zip Co	ide)		
2	Craig R. Kil	1man			2128 Eas	tridge R	d., Timon:	ium, MI	210	193	
	AND METHOD OF DISBOSITION		20b. PLACE	OF DISPO	SITION (Name of cer	netery, crematory or	20c. L	OCATION - City			
	1 Burtel 2 Committee 3 Inch	oval from State	Motor pla	,	ematory.	The May,		tonsvil	110	MD	
	M SIGNATURE OF FUHERAL SERVICE LIC	ENGES /	HELL	0 01		D ADDRESS OF FA		-OIISATI	TE,	TID	
	Louis	10 de	mos		Lemm	on Funer	al Home				
	rowell	Lemmon	8390		10 W	. Padoni	a Rd., Ti	nonium.	MD	21093	
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Interval Between										
	IMMEDIATE CAUSE (Fine)	List Dnly one ceus	e on each line								nd Deeth
	disease or condition	COLO	N CANC	EB						FEB.	199
1	resulting in deeth)	DUE TO (OR AS A CONSEQUENCE OF):								۱ ۵۵,	133
<u> </u>	_	•						İ			
CERTIFICATION	Sequentielly list conditione,	b	OR AS A CONSEC	UENCE C	Fi:	<u> </u>				1	
A	if eny, leading to immediate cause. Enter UNDERLYING				.,.					İ	
5	CAUSE (Disease or Injury	C. DUE TO (	OR AS A CONSEC	HENCE C	E).					<del></del>	
Ē	thet initieted events resulting in deeth) LAST	502 10 (	DIT NO A CONCE	JOENIOE C	• /-					İ	
<b>H</b>		d							-	<del> </del>	
_ 1	PART II. Other eignificent condition	is contributing to c	leeth but not r	eeuiting	in the underlying	g cause given in				ERE AUTOPSY	
8	ALZHEIMER'S DIS	SEASE						PRMED?		MPLETION O	
MEDICA	PERNICIOUS ANEN	UT A					1 □ YES	2 NO		F DEATH?	
Σ	LEMACTORS ANE	VI A					_	`	1 1 (	YES 2	] NO
z											
3	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			26. PI	ACE OF DEATH (C)	neck only one)				
PHYSICIAN:	1 TYES 2 NO	1 🗆 Inpetient 2 🗆	ER/Outpetlent 3	□ DOA		e 5 🗆 Raeldence	8 🗆 Other (Specify)				
Ŧ	27. MANNER OF DEATH	26s. DATE OF II (Month, De)		20b. TII	JURY 28c. INJ	URY AT	28d. DESCRIBE HOW	INJURY OCCUP	RED		
BY	Natural 5 Pending  Accident Investigation					YES 2 NO					
	3 Suicide 8 Could not be	28e. PLACE OF	INJURY Al ho	ma, farm,	atreet, fectory, offic	•	201. LOCATION (Street	end Number or	Rural Rout	te Number,	
里	4 Homicids determined	ounding, e	···· (opeony)				City or Town, Stell	"			
<b>W</b>	29e. CERTIFIER										
MP	Check only (Check only one) 20 MEDICAL EXAMINER: On the beet of my knowledge, death occurred at the time, date end place, end due to the cause(a) and manner as stated.  (Check only one) 2 MEDICAL EXAMINER: On the beet of exemination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) end manner ee stated.										
COMPLETED				vacrysti	on, in my opinion, c			doe to the c	.vuos(d) di	THE THE INTERIOR	, otateu.
BE (	29b. SIGNATURE AND TITLE OF CERTIFIE	n Vai	The h	^		29c. LICENSE NU	MBER	29d. DATE S	IGNED (M	lonth, Day, Yea	ar)

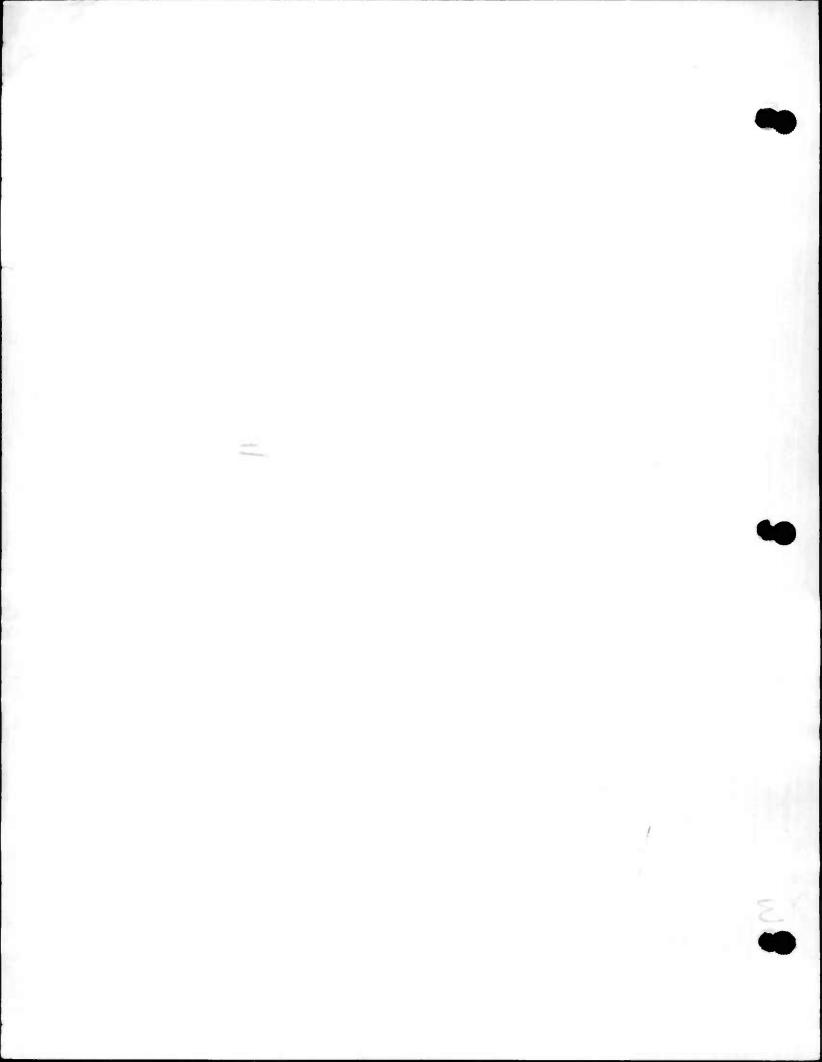
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APRIL

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

617A Stemmers Road. Run Balto

APR 2 8 1995



FOR STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Philip J Klemkowski April 9:00pm 19, 1995 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year)
May 15, 1937 8. BIRTHPLACE (State or Formica) 212-36-2366 HOURS XXM 2 | F 57 DAYS Maryland permit, Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 1146 Hull Street DIRECTOR Baltimore City N/A RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY N/A Baltimore City 1 X XES 2 | NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? hospital or attending physician. tached for use as the burial-transit 1146 Hull Street 21230 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYPES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yee, specify Cuban, Mexican, Puerto Ricen, etc.)

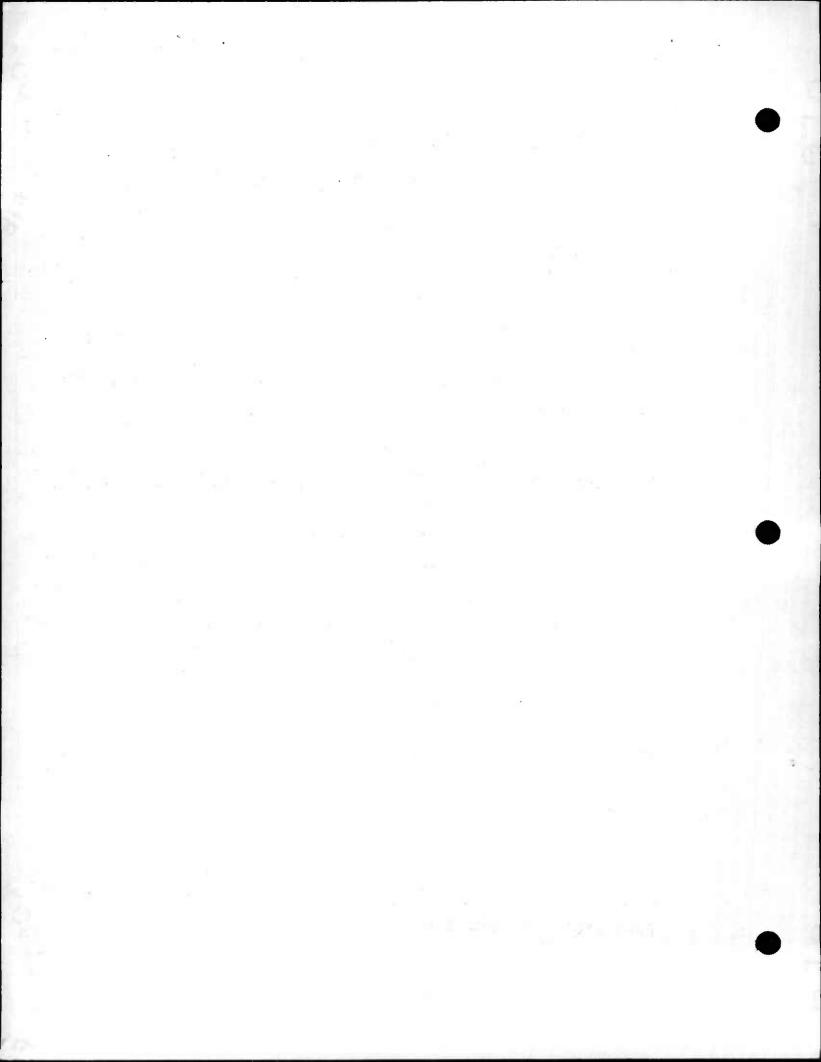
1 YES 2 TONO Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. Never Married 2 Merried IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced Specify: White 12/10/55 - 10/30/58 COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) N/A detached f 12th n/a Clerk once. 17. FATHER'S NAME (First, Middle, Last) / be retained by the hage 5 should be detail 18. MOTHER'S NAME (First, Middle, Maiden Surname) Philip Klemkowski Bielinski Frances BE funeral director, page 5 should notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Lorie A. Tiesi 1500 E. Fort Avenue, Baltimore, MD 21230 pe 20a. METHOD OF DISPOSITION

XXBuriel 2 Cremetion 3 Removal from State hours after death. Page 6 may 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State must Holy Rosary Cemetery, 4 Donation 6 Other (Specify). 21, 1995, April MD medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Charles L. Stevens Funeral Home, Inc filled in by the filon, or removal. 1501 E. Fort Avenue, Baltimore, MD 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate 0 ahock, or heart failure. List only one cause on each line. Interval Between cremation, or IMMEDIATE CAUSE (Final Musseul My dantas miseration
UE TO (OR AS A CONSEQUENCE OF):

LOY May artey Disease
UE TO (OB, AS A CONSEQUENCE OF):

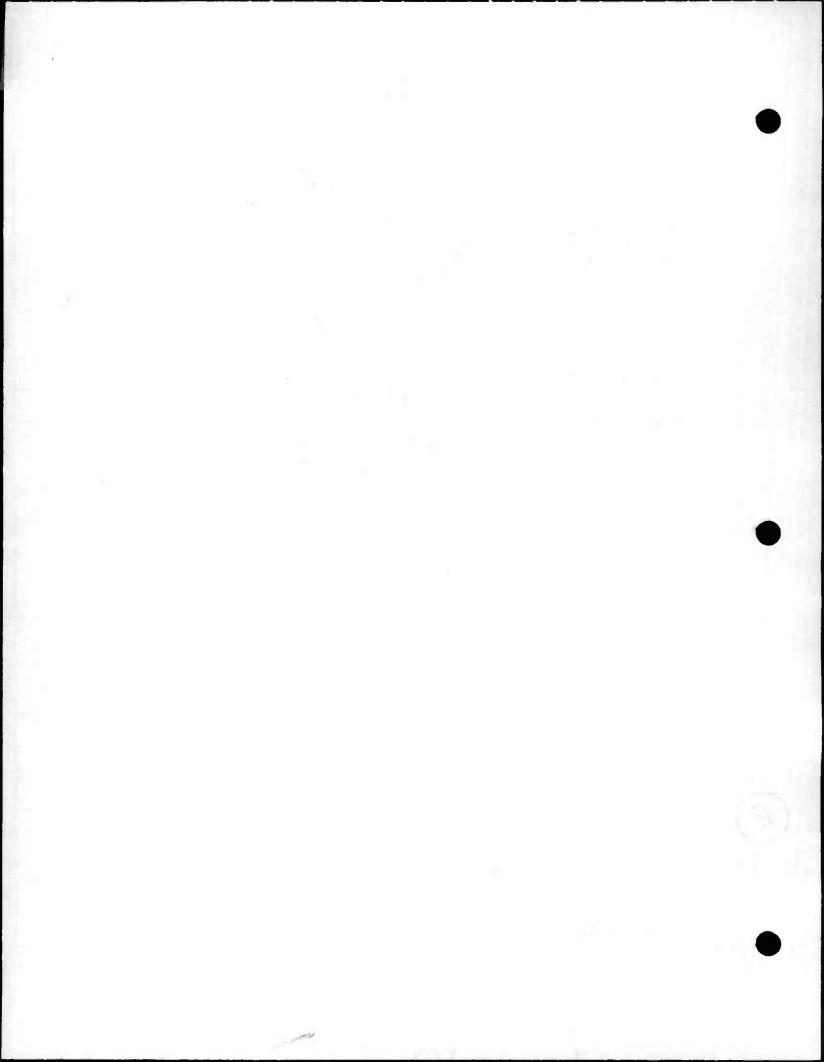
LOY Pluteum Caustio Vasculus Occasio **Onset and Death** the disease or condition 5 nein completely traumatic event, resulting in death) prior to burial, CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING the death certificate be CAUSE (Disease or injury DUE TO that initiated events the attending p resulting in death) LAST ö PART II. Other aignificant conditions contributing to death but not reaulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS signed by t Health and PERFORMED? AMILABLE PRIOR TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that any COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO shows a 1 YES 2 NO has been Dept. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) this certificate h OTHER:
4 □ Nursing Home 5 Residence 8 □ Other (Specify) 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 5 27. MANNER OF DEATH 28e, DATE OF INJURY 28c. INJURY AT WORK?
1 YES 2 NO 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Netural DIRECTOR: After the hours after death BY Investigation 2 Accident 28 Is n 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be COMPLETED 4 Homicide Item 29e. CERTIFIER (Check only one)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner es stated. FUNERAL I -2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end menner ee stated. TO THE HOSPITA
TO THE FUNERA
be filed within 72
IMPORTANT: II 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE m April 20, 1995 10730 5 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Silvino neses M.D. 31. DATE FILED (Month, Day, Year) APR 2 8 1995



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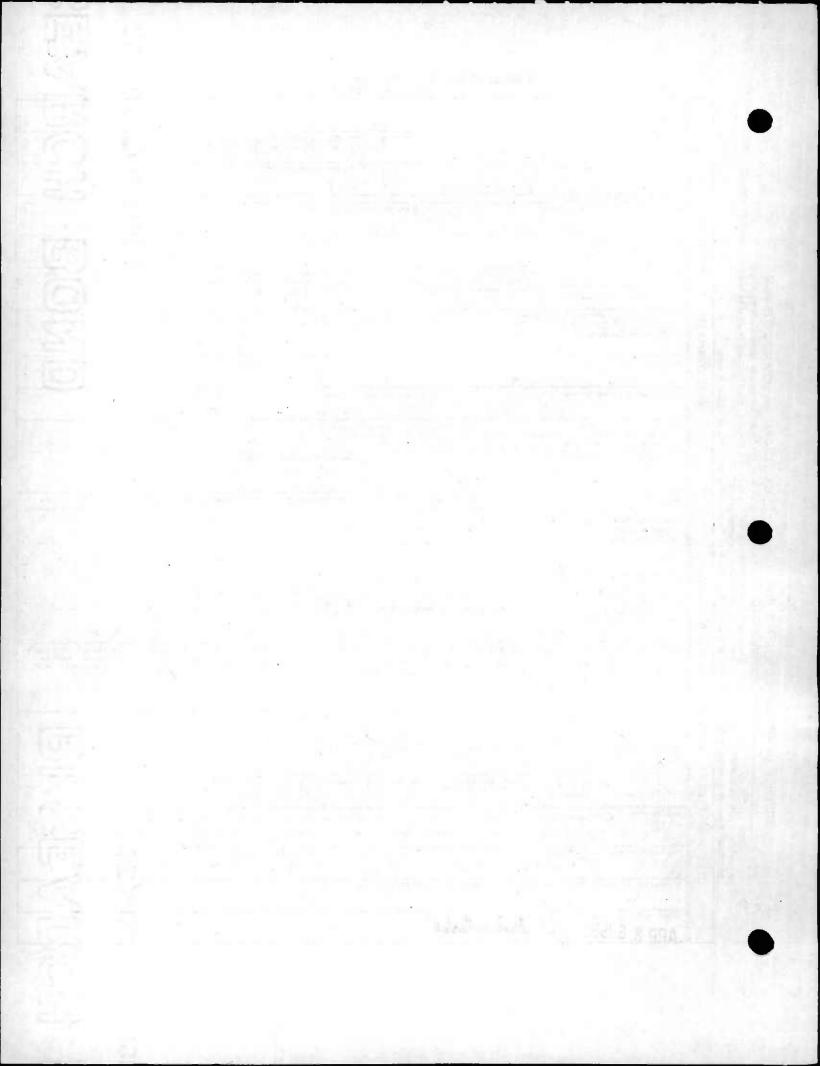
		1 - FOR STATE OF MARYLAND / DEPARTMENT CERTIFICATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
	N. Legistra	1. DECEDENT'S NAME (First, Middle, Last) Thelma D. Larkins	2. DA MOI A DI	TE OF DEATH	3. TIME OF DEATH						
,		4. SOCIAL SECURITY NUMBER  216-20-4977 1 M 2 V F 69 YRS. MONTHS			BIRTHPLACE (State or Foreign Country)						
2, 3 should	стоя	98. FACILITY NAME (I not institution, give street and number) LI DEPTY NEd COI CENTER P	TOWN OR LOCATION OF DEATH	9c. COUNTY	OF DEATH						
Pages 1,	DIRECT	10a. STATE 10b. COUNTY 10c. CITY, TOWN O			10d. INSIDE CITY						
sit permit.		100. STREET AND NUMBER  100. STREET AND NUMBER  100. STREET AND NUMBER  100. STREET AND NUMBER  100. STREET AND NUMBER  100. STREET AND NUMBER  100. STREET AND NUMBER  100. STREET AND NUMBER	101. ZIP CODE	10g. CITIZEI	1 PYES 2 NO						
020 physician. burial-trans	FUNERAL	1 Never Married 2/ Married FORCES? 1 YES 2 V NO II	WAS DECENDENT OF HISPANIC ORK yes, specify Cyben, Mexican, Puerl	SIN? (Specify Yea or No.— 14 o Rican, etc.)	. RACE — American Indian, Black, White, etc.						
21215-0020 al or attending physic for use as the burlal	ED BY	3 Wildowed 4 M Divorced  15. DECEDENT'S EDUCATION  16e. DECEDENT'S USUAL OC	☐ YES 2 1 NO Specify:	8b. KIND OF BUSINESS/INDUS	Black						
YLAND 21215-0020 by the hospital or attending physician. be detached for use as the burial-tran at once.	APLET	(Specify only highest grade completed)  (Give kind of work done of life. Do lyOr use retired.)  College (1-4 or 5+)	maker	Own H	ome						
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit permit. Pages 1, 2, notified at once.	E COMPL	Daniel Smothers	18. MOTHER'S NAME (FIRS	t, Middle, Meldee Surname)	$\cap$						
	TO B	JOYCE DUKES 118 MI	(Street and Number or Rural Route No.	mber, Gry or Town, State, Zip Co	1.21207						
ALTIMORE, death. Page 6 may be tuneral director, page axaminer must be		20s. METHOD OF DISPOSITION 1  Buriel 2  Cremation 3  Removal from State 4  Donation 5  Other (Specify)	BLOGE 5/		Co, Md						
BALTIMORE, after death. Page 6 may be by the funeral director, page moval. cal examiner must be i		21. SIGNATURE OF FUNERAL SERVICE LICENSEE	SEPH LIKUS	s, Funera	1 Home						
e in the		23. PART (Enter the diseases, or complications that caused the death. Do not anter shock, or heart failure. List only one cause on each line.	the mode of dying, such as co	ardiac or respiratory arrest	t, Approximata Interval Between						
ithin 24 etely fille emation, nt, the		IMMEDIATE CAUSE (Final disease or condition resulting in death)  a. Hepatic Failum  DUE TO (OR AS A CONSEQUENCE OF):	'2		Onset and Death						
C 6876( executed wind and complete or burial, created windle)	NO	Sepsis			2uks						
	CATIC	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury			iwk						
certific ding p lygien	CERTIFICATION	that initiated events resulting in death) LAST									
	AL CE	PART II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	24e. WAS AN AUTOPSY PERFORMED	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO						
COR ires that signed b lealth ar	MEDIC			1 YES 2 NO	COMPLETION OF CAUSE OF DEATH?						
	N: M	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES N			1 TES 2 NO						
一年 皇皇 曹	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO 1 In Inpatient 2 ER/Outpatient 3 DOA 4 Nurs		her (Specify)							
PHY with		27. MANNER OF DEATH  28a. DATE OF INJURY (Month, Day, Year)  28b. TIME OF INJURY (Month, Day, Year)		ESCRIBE HOW INJURY OCCUR	NED						
THE ON THE CHART CASE IS MAY	TED BY	2 Accident Investigation 3 Suicide S Could not be determined  28e. PLACE OF INJURY — At home, lerm, street, factor building, atc. (Specify)	ory, office 28f, Le	OCATION (Street and Number or ty or Town, State)	Rural Route Number,						
Thousan III	COMPLET	29e. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the illumone)									
TO THE HOSE TO THE FUNE Be filed within		2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my of  29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER		ause(a) and manner as stated.  IGNED (Month, Day, Year)						
TO THE DE filed WPOR	TO BE	Jeorge E. Wills III. M.D.  30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	041365	► Ap	vil 26, 1995						
0		George E. Wicks III M.D. 2600	Liberty Hei	ghts Ave.	21215						
0		APR 2 8 1995 Jahr Diener Randell									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

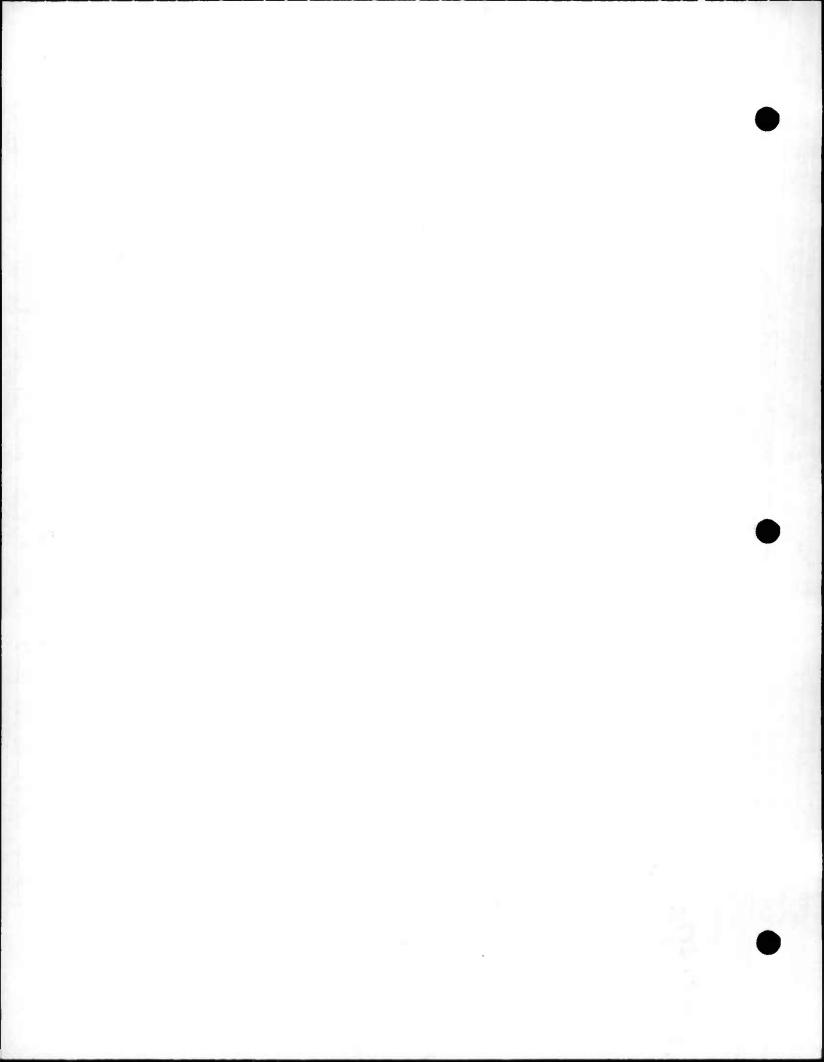
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the funeral director, page 5 should be detached for use as the bunial-trans

	1. DECEDENT'S NAME (First, Middle, Las	st)		7.00		2. DATE OF MONTH	DEATH	YEAR	3. TIME OF DEATH
	Carl Frank Lane					April	24, 199	95	6:00 A.
	4. SOCIAL SECURITY NUMBER 213-22-1573		GE (In yrs. last birthday)  YRS.	MONTHS DA		/A 4	Day, Year)	Coun	HPLACE (State or Fore try) Vland
	9e. FACILITY NAME (If not institution, give street end number)  9b. CITY, TOWN OR LOCATION OF DEATH  9c. COUNTY OF DEATH								
TOR	Meridian Homewood	od Nursing Ho	ome	_ Balt	imore		Ba1	timor	ce City
DIRECTOR	Maryland Anr	ne Arundel		ry, rown on u Pasader					10d. INSIDE CITY LIMITS? 1 YES 2 N
FUNERAL	10e. STREET AND NUMBER				10f. ZIP CODE	200	10g, (	CITIZEN OF	WHAT COUNTRY?
NEF	1335 Old Mountai		LECL		21122				States
B	1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 K Y IF YES, GIVE WAR OF KOREAR	ES 2 NO R DATES	If yes	DECENDENT OF HIS s, specify Cuben, Mer YES 2 XNO Sp	xican, Puerto Ric	Specify Yes or No- an, etc.)	14. RAC Blac Spec	E — American Indian ck, White, etc. city: White
TED	15. DECEDENT'S EI (Specify only highest gra	PATION g most of working	16b, K	IND OF BUSINESS/	INDUSTRY				
	Elementery/Secondery (0-12)	College (1-4 or 5+)	Iffe. Do NOT I	use retired.)	y most or worting		14.21		
COMPLET	12 yrs		Contr	actor			Building		
	17. FATHER'S NAME (First, Middle, Last)	c olo a wt					dle, Meiden Sumeme	•)	
TO BE	Carl Francis Lar	enart	19h MAII IN	G ADDRESS /~	Nora  Nora  Teet and Number or Ru	Scannel		7in Carta	
	Mrs. Carol Jeros	simich			rive Pasa			zip Gode)	
	20a. METHOD OF DISPOSITION		20b. PLACE AND DATE	OF DISPOSITIO		DATE	20c. LOCATION	- Cify or T	own, State
	1. Suriel 2 Cremation 3 Re 4 Donation 5 Other (Specify)		Glen Have	n Mem.	Pk. 4/26	1			nie, MD
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	Y=	22. NAM	E AND ADDRESS OF	FACILITY FALSE	oral Ho	ma	Service Char
4	· (ou I	(bauo	()		_				
	23. PART I. Enter the diseases, o ahock, or heert felium IMMEDIATE CAUSE (Finel disease or condition resulting in death)	e. List only one cause or	n each line.	not enter the	mode of dying, a	such es cardia	c or reepiratory	arrest,	Approximet
IFICATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate couse. Enter UNDERLYING CAUSE (Disease or injury that initiated events	a.  DUE TO (OR A  DUE TO (OR A	when	OF):  OF):  OF):	mode of dying, a	such es cardia	c or reepiratory	arrest,	Approximet
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		1. DECEDENT'S NAME (First, Middle, Last,	)				2. DATE OF DEATH MONTH	DAY YE	3. TIME OF DEATH
		Marvin	М.	Long			April 26	1005	5:12 P
P		4. SOCIAL SECURITY NUMBER 214-68-3798	15€ M 2 □ F	38 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 10-21-	56	BIRTHPLACE (State or Foreign Country)  MD •
should	~	9s. FACILITY NAME (If not institution, give			ı	OR LOCATION OF DI	EATN	9c. COUNTY	OF DEATH
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Des 1.	EC	10a. STATE 10b. COUN			Y, TOWN OR LOCA	TION			10d. INSIDE CITY
permit. Pages	L DIRE	MD.  10e. STREET AND NUMBER	Anne Arunde	el BAI	TIMORE	Glen B	urnie		LIMITS?
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	BY	1X Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 TYE	DATES	If yes, sp	ecify Cuban, Mexica 2 X NO Specif	in, Puerto Rican, etc.)		Black, Whita, alc. Specify: BLACK
by the retained by the hospital or attending page 5 should be detached for use as the be notified at once.	0	16. DECEDENT'S EDI (Specify only highest grad	UCATION de completed)	16a. DECEDENT'S	USUAL OCCUPATION	ON Control of weeking	16b. KIND OF BE	USINESS/INDUST	RY
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		20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Ren 4 Donation 5 Other (Specify)	moval from State	tob. PLACE AND DATE ( remetery, grematory or o	OF DISPOSITION (Na ther place)		DATE 20c, LO	OCATION — City	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s
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8 - 2 -	$\vdash$	23. PART I. Enter the diseases, Dr	complications that cause	and the death. Do	638	N. GII	MOR STRI	TET .	21217
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를 통을 들	L C	PART ii. Other significant condition	na contributing to daath	but not resulting	n the underlying	g ceuse given in	Part i. 24s, WAS AI	N AUTOPSY	24b. WERE AUTOPSY FINDINGS
) = B = 6	MEDICAL						PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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R: After death	D BY	2 Accident Investigation 3 Suicide 6 Could not be	26s. PLACE OF INJUR	RY — At home, farm, a		res 2 No	281. LOCATION (Street City or Town, State	and Number or Ru	ural Route Number,
OR ATTENDING DIRECTOR: After hours after death	373	4 Nomicide determined							
# ZA F	COMPLE	(Check only	SICIAN: To the best of my kno ER: On the bests of examinati						use(a) and manner as stated.
TO THE HOSPI TO THE FUNER be filed within	BE	29b. SIGNATURE AND TITLE OF CERTIFIE	in and			29c. LICENSE NUM			NED (Month, Day, Year)
는 문용 <b>를</b>	5	- 00-	HO COMPLETED CAUSE OF D			D1767		4/	27/95
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		1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
		1. DECEDENT'S NAME (First, Middle, Lest)	Josephine				2. DATE OF C	DEATH DAY	1995	3. TIME OF DE 4:30	EATH D. M
Pi		4. SOCIAL SECURITY NUMBER 212-01-9622	5. SEX 8. AGE (	In yrs. last birthday) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)  Mar 22, 1913  8. BIRTHPLACE (State or Foreign Country)  Maryland				
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iit. Pages 1	OIR	106. STATE 106. COUNTY Maryland	** **			altimore	City			10d. INSIDE CLIMITS?	
in. ansit perm	FUNERAL	10e. STREET AND NUMBER 4328	Berger Avenue 2			H. ZIP CODE				of what country?	
IORE, MARYI e 6 may be retained by ector, page 5 should be must be notified at	B	11. MARITAL STATUS 1 Never Married 2 Married 3 Midowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO If yes, specify Cuban 1 ☐ YES, GIVE WAR OR DATES			pecify Cuban, Maxica	n, Puerto Rican	pecify Yea or i, etc.)		RACE — American in Block, White, etc. Specify: Whit	
	COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	INTON  Inspired of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second				lt i mor				
		17. FATHER'S NAME (First, Middle, Last)	ames A. Berar			18. MOTHER'S NA		le, Malden Sun		cy School	. 3
	TO BE	19a. INFORMANT'S NAME (Type/Print)  Newton J. Malla	19b. MAILING ADDRESS (Street and Number or Rural I					City or Town, S			
		20a. METHOD OF DISPOSITION  1 X Burlel 2 Cremation 3 Ramo 4 Donation 8 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LIC	cem HC	Holy Redeemer Cem. 4/29/95   Baltimore,						e, Maryl	and
00 L 0 E		· milto	Milton I k	U.L.	5305	Harford	Rd.	Baltin	nore,	ck, Inc. Md. 2121	4
in 24 hours ely filled in b nation, or rei , the medi		23. PART I. Enter the diseases, or c shock, or heart fallure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one couse on e	ech ilne.					ory arrest,		Between and Death
P.O. BOX 6876 th certificate be executed tending physician and com il Hygiene prior to burial, or other traumatte ev	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a. Cardiac arrest  OUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  d.								
ORC that the	MEDICAL C	PART II. Other algnificent conditions	s contributing to deeth be	contributing to death but not resulting in the underlying cause given in				WAS AN AUT PERFORMEI	D?	24b. WERE AUTOPSY AMAILABLE PRIC COMPLETION OF OF DEATH?  1 YES 2	DR TO F CAUSE
	SICIAN:	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		F DEATH YE	H (Check only one)		10				
OF VITAL HYSICIAN: The law his certificate has with the State Dep ked, or item 23	PHYSI	1 U YES 2 NO 27. MANNER OF DEATH	HOSPITAL: 1 Inpetient 2 ER/Outpi 28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c, INJ	IURY AT DRK?	8 Other (Spe 28d. DESCRIB		RY OCCURE	0	
DIVISION OF VI.  DR ATTENDING PHYSICIAN: DIRECTOR: After this certifications after death with the St.  tem 28 is marked, or it	ED BY	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be determined	28s. PLACE OF INJURY building, etc. (Speci	- At home, farm, s	M 1 🗆	YES 2 NO	28f. LOCATION City or Tox	N (Street and i	Number or Re	ural Route Number,	
D GR DIR	COMPLET		CIAN: To the best of my knowless: On the basis of examination							use(s) and menner a	n stated
TO THE HOSPITAL TO THE FUNERAL be filed within 72 IMPORTANT: If	BE	295-SIGNATURE AND TITLE OF CERTIFIER		m	M	D257				NED (Month, pay, Year)	
1	5	Dr. Duncan Salm	COMPLETED CAUSE OF DEA			p. Balt.	Md.	5601	Loch	Raven Rly	vd
2		31. DATE FILED (Month, Day, Year) ADD 9 8 1995	32. REGISTRAR'S SIGNA				,	3001			



DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR **CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH AM 2. DATE OF DEATH Kimberly Denise 1995 Moore April 8:30 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year, IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreig Country) IF UNDER 24 HRS. HOURS 215-78-3822 1 M 2 1 0 35 July Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 1505 Carrera Lane Arnold Anne Arundel RESIDENCE OF DECEDENT 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Anne Arundel Arnold 1 YES 2 NO Dermit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1505 Carrera Lane 21012 by the funeral director, page 5 should be detached for use as the burial-transit removal. USA hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married BY Specify: 3 Widowed 4 Divorced White ETED. 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only higher Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 Homemaker Household 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) William J. Robbins, Jr. to Beulah May Anderson BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zio Code) 2 Beulah May Bennett 200 South Elm Avenue, Highland Springs, VA 23075 be 20a. METHOD OF DISPOSITION
1 Burlel 2 A Cremation 3 Re 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must Metro Crematory or other place) 4 Donation 5 Other (Specify) Baltimore. MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY
Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 the medicai 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feliure. List only one cause on such line. n and completely filled in by to burial, cremation, or remo Approximata shock, or heart feliure. List only one cas interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) Angertail infaction event, DUE TO (OR AS A CONSEQUENCE OF) executed Congestion heart failine traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate the attending physician i Mental Hygiene prior to requires that the death certificate be DUE TO (OR AS A CONSEQUENCE OF) cause. Enter UNDERLYING hyperten CAUSE (Disease or Injury other that initiated events resulting in death) LAST Bhm 10 PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE been signed by th 13thy roid 3m shows any HIV infect si 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has b OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only on certificate to the State OTHER:
4 | Nursing Home | S | Rasidence | B | Other (Specify) HOSPITAL 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, this ( 1 Natural
2 Accident 5 Pending М 1 YES 2 NO BY After t 3 Sulcide 28s. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: A 2 hours after of filem 28 is 20 6 Could not be determined 4 Homicide COMPLET 29a. CERTIFIER
(Check only one)

29 MEDICAL EXAMINES: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL O
TO THE FUNERAL DI
DE filed within 72 ho
IMPORTANT: If ite 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the ceuse(s) and manner ee stated. SAGMATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) **BE** 4/27/88 41339 2 AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 12m MO 21201 14-211

BALTIMORE, MARYLAND 21215-0020

once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should hours after death. Page 6 may be retained by the hospital or attending physician. notified at 99 must funeral director, injury, or other traumatic event, the medical examiner been signed by the attending physician and completely filled in by the into the latth and Mental Hygiene prior to burial, cremation, or removal. PHYSICIAN: The law requires that the death certificate be executed with item 23 shows any Dept. certificate has the the state Dept marked, or with th ž f TO THE HOSPIT TO THE FUNE be filed within

PHYSICIAN:

ВҰ

COMPLETED

BE

2

XYES 2 NO

5 Pending

Investigation

27. MANNER OF DEATN

Natural

2 Accident

4 Nomicide

3 Sulcide

95-2394-510 95 | 3082 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR LOUIS MOORE 0:30 APRII 95 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign 1 X M 2 - F 9e. FACILITY NAME (If not institution, give str 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEAL DIRECTOR W.NORTH AVE BALTIMORE CITY RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MORE 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? 1216 WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No. If yes, specify Cuban, Mexicen, Puerto Rican, stc.)
 U YES 2 NO Specify: - American Indian, White, etc. 1 Never Merried 2 Merried В 3 Widowed 4 Divorced ORBAN COMPLETED 15. DECEDENT'S EDUCATION ecify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ve kind of work done Do NOT use retired.) (0-12)College (1-4 or 5+) DERVISITE BE 19h MAII ING ADDRESS 9 METHOD OF DISPOSITION ACE AND DATE OF DISPOSITION (Name of 4 Donation 5 🗆 23. PART C Smlar the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory shock, or heert fallure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Finel **Onset and Death** disease or condition resulting in death) APTELIOSCIEROTIC CARPLOVASCULAR PISEASE DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 TYES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN

25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) EXAMINER? HOSPITAL:

1 - Inpatient 2 - ER/Outpatient

28e. DATE OF INJURY (Month, Day, Year)

OTHER

4 Nursing Nome XXResidence 6 Other (Specify)

28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 YES 2 NO

26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street end Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner ee stated.

2 X MEDICAL EXAMINER: On the estigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end manner ee stated.

29c. LICENSE NUMBER

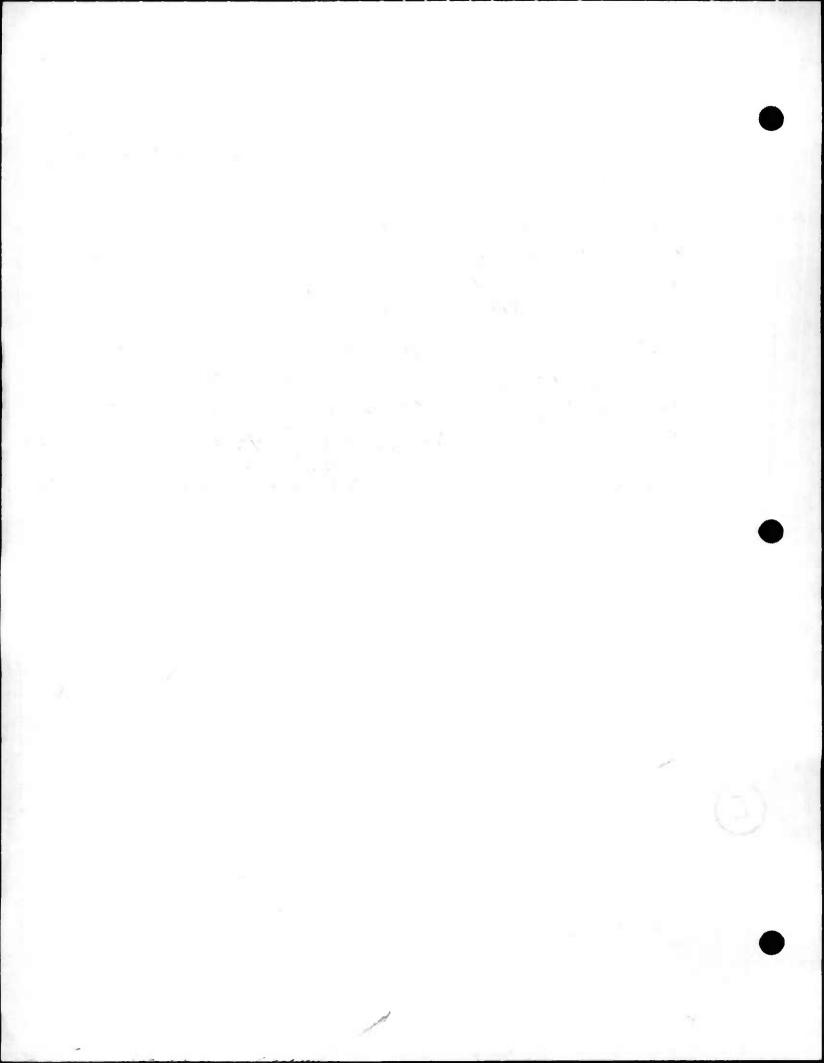
O.C.M.E.

29d. DATE SIGNED (Month, Day, Year) APRIL 25,1995

OF ATT (ITEM 27) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

32. PAGISTRAR'S SIGNATURE



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burjal-transit nermit. Pages 1 - 2 schould
be filed within 72 hours after death with the State Dept, of Heatth and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

											95	5 1	3083	
	1 - STATE REGISTRAR	STATE OF M	MARYLAND /	DEPAR					MENTAL	HYGIE!				
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE C	OF DEATH		- 3	3. TIME OF DEATH	
	JAMES	HUGHES		MAL	IANI				MONTH	1	YAC	YEAR		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les			R 1 YEAR	IF UNDER	24 HRS.	7. DATE C	E BIRTH	1995	a BIRTHRI	4:42 am M	
1	216-18-0375	1 💢 M 2 🗆 F	X м 2 □ F 71			DAYS	HOURS	MIN.	(Month,	Day, Year)	1022	Country)		
	9a. FACILITY NAME (If not institution, give st	reet and number)	. – /1			Y TOWN C	DR LOCATI	ON OF DE		t 17,		NTY OF DEA		
<u>۳</u>	Saint Joseph Medic										7.15	altimon		
DIRECTOR	RESIDENCE OF DECEDENT											MI MI I I I		
E						OR LOCAT						1	Od. INSIDE CITY LIMITS?	
	Maryland  100. STREET AND NUMBER	N/A			Balt	imore							X YES 2 NO	
FUNERAL						101	. ZIP COD	_			10g. CIT	IZEN OF WH	AT COUNTRY?	
W.	4401 Willshire						212					nited	States	
5	11. MARITAL STATUS  1 Never Married 2 X Married	12. WAS DECEOEN FORCES? 1	T EVER IN U.S. AF	RMED NO	13.	. WAS DEC	ENDENT C	OF HISPAN	HC ORIGIN?	(Specify Ye	s or No—	14. RACE -	- American Indian, White, etc.	
BY	3 Widowed 4 Divorced	IF YES, GIVE W				1 TES				ceri, etc.)		Specify:		
ED E		WW II											White	
12	15. DECEDENT'S EDUC (Specify only highest grade	completed)	(G	CEDENT'S live kind of Do NOT u	work done	during mo		ng	16b.	KINO OF BU	JSINESS/IND	DUSTRY		
1 2	Elementary/Secondary (0-12)	College (1-4 or 5 d	+)		-	,				Manu	£+.			
COMPLET	17. FATHER'S NAME (First, Middle, Last)			Weld	ier					_	factu	iring		
		shan C.							ME (First, Mi		Surname)			
H	James Hughes Ma	anon. Sr.							ret Ba					
ဥ	Mrs. Jean L. Mah	nn -	19			SS (Street a			Route Numbe			Md.	21206	
	20a. METHOD OF DISPOSITION	211	20b. PLACE			_		Vent	-					
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	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE Mark	T 7avo	Vna		. NAME AN				100	<b>43011</b> ,	rial y	Tanu	
	> Marle T. 9	ALOXOVA-	I. Zavo	yna		Leon	ard	J. R	uck,					
						5305	Har	ford	Road	l Ba	ltimo	re, M	d. 21214	
	23. PART I. Enter the diseases, or complications that caused the daeth. Do not enter the mode of dying, auch as cardiac or reapiratory arrest,										Approximate			
	IMMEDIATE CAUSE (Final		oo on paon mie										Interval Between Onset and Death	
	disease or condition recuiting in death)	PROBA	BLE MAS	SIVE	<b>LSPF</b>	RATIO	N						IMMED.	
			(OR AS A CONSE										1	
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E .	resulting in death) LAST	1												
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Ë	DID TOBACCO USE CONTR	RIBUTE TO CA	USE OF DEA	TH YE	S 🗆	NO 🗆	UNC	ERTAIN	V X					
l ĕ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLAC	E OF DEAT	TH (Check	only one)								
SIC	1 TES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHE 4 Nu		e 5 □ Re	sidence	8 Other	(Specify)				
PHYSICIAN:	27. MANNER OF DEATH	28s. DATE OF		28b. TIM	E OF	28c. INJ	URY AT				INJURY OC	CUREO		
ВУ Б	Netural 5 Pending	(Month, D	ay, roar)	INJ	URY M	1 Y	RK7 'ES 2	] NO	28d. 0ESCRIBE HOW INJURY OCCUREO					
	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE O	F INJURY — At ho	me, farm, s	street, fac	tory, office	,		28f. LOCAT	TION (Street	and Number	or Rural Rou	ite Number.	
Ē	4 Homicide determined	building,	etc. (Specify)						City or	Town, State	)			
COMPLETED	29e. CERTIFIER	MANA TO ME S TO A						72.5						
MP	(Check only one)												U:	
8	2 MEDICAL EXAMINE		ANTION BOOK	veztigatio	ıı, ın my	opinion, de	eath occur	ed at the	time, data a	nd place, a	nd due to th	ne cause(a) a	nd manner as stated.	
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	1 1					29c, LICE	ENSE NUM	IBER		29d. DAT	E SIGNED (M	Ionth, Day, Year)	
0	goginder P	Meht	ami				D 4	1410			0	4-27	1-95	
FI	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	SE OF DEATH (ITE	M 271 /Time	Deint)									

1201

30. NAME APPLADORESS OF PERSON WHO COMPLETE

JOGINDER P. MEHTA, MD

31. DATE FILEO (Month, Day, Year)

APR 2 8 1995 ST. JOSEPH MEDICAL CENTER TOWSON,MD 21204 32. REGISTRAR'S SIGNATURE

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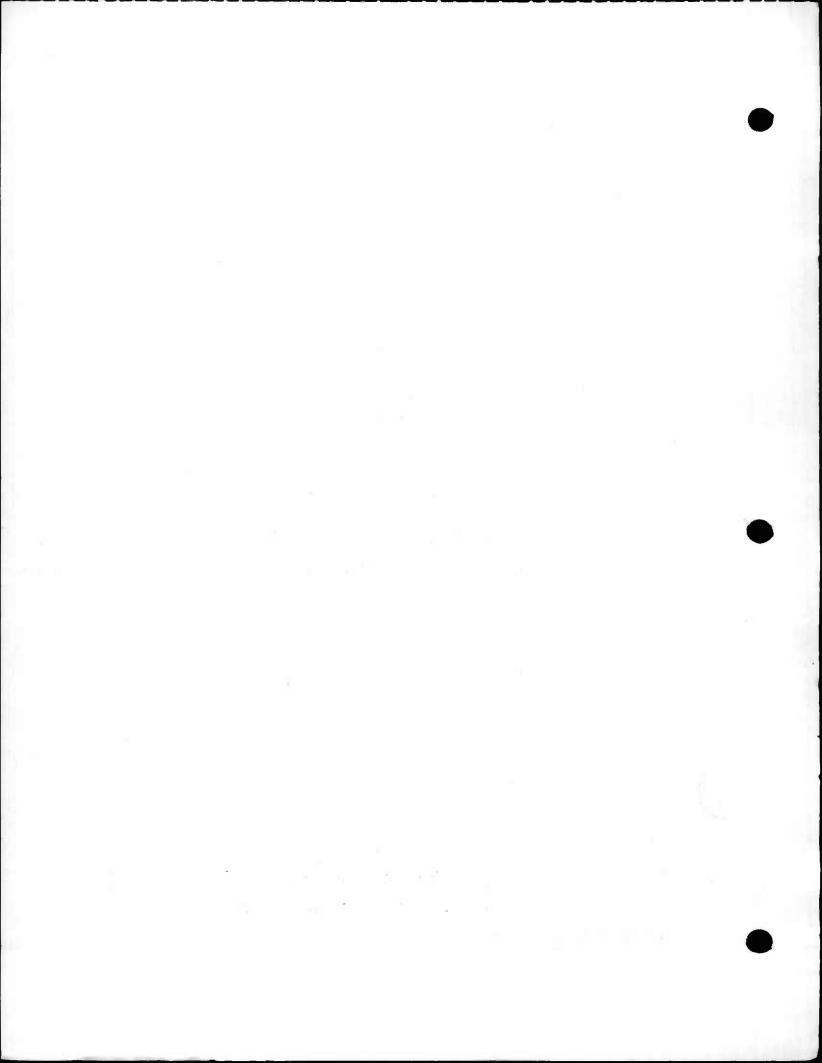
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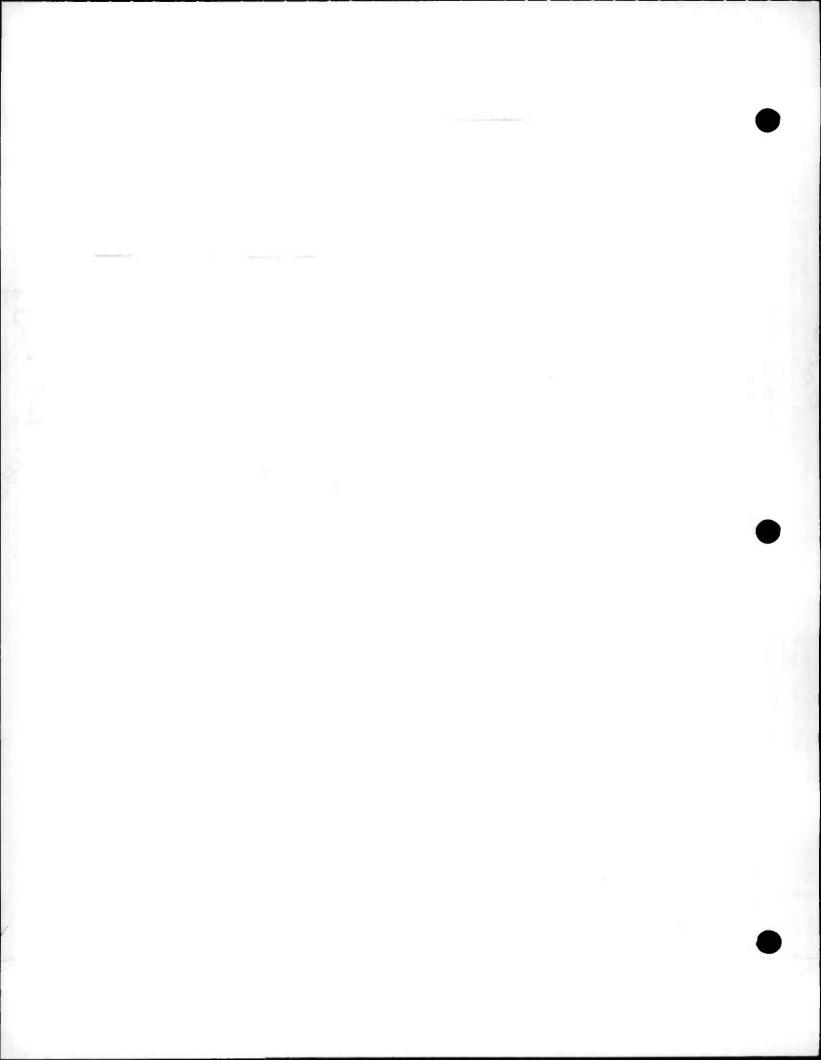
JOSINDER P. MEHTA MD. ST. JOSEPH MEDICAL CENTER TOWSON ND. 21204

			1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF I		MENT	AL HYGIEN			
		- 8	1. DECEDENT'S NAME (First, Middle,	Last)				2. DAT	E OF DEATH	AY ·		TIME OF DEATN
			BRUCE ARTHUR M	OORE						Ž, 199	5	12:15 P. M
1, 2, 3 should	Dis		4. SOCIAL SECURITY NUMBER  214-80-2539	1 € M 2 🗆 F	(In yrs. lest birthdey)	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Ser	e of Birth oth, Day, Year)	1962	Mar	
	ζ,	стоя	9e. FACILITY NAME (If not institution, give street and number)  9b. CITY, TOWN OR LOCATION OF GEATH  Stella Maris Hospice  RESIDENCE OF DECEMENT  9c. COUNTY OF DEATH  TOWSON  Baltin									
3	Lages Lages	DIREC	Md . 10b. Co		10c. Ci	TY, TOWN OR LOCA	Washir	ngto	n			INSIDE CITY LIMITS?
Î	permit.	ERAL	10e. STREET AND NUMBER			10	H. ZIP CODE			10g. CITIZE		T COUNTRY?
۔ ا	IISUE	띮	6607 Bonni	e Ridge Driv	'e		2	2120	9	US	SA	
215-0020 attending physician.	5	BY FUNE	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER (FORCES? 1 YES, GIVE WAR OR D	2 NO	If yes, sp	CENDENT OF NISPA pecify Cuben, Maxico S 2 0 NO Specif	in, Puerlo	IN? (Specify Yes Rican, stc.)	or No- 14	Specify:	American Indian, India, etc. White
215-0	nse ds		15. DECEDENT'S (Specify only highest		16e. DECEDENT'S	S USUAL OCCUPATI work done during me	ON ont of working	16	b. KIND OF BU	SINESS/INOUS	STRY	
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The the	by the hospit be detached at once.	8	17. FATHER'S NAME (First, Middle, Lest)  18. MO						Middle, Maiden	Surname)		
		H	Earl F. M  196. INFORMANT'S NAME (Type/Print)				C1	mer	ia B.	Bray	mer	
MAR retained	notified	2					and Number or Rural					
- 2 2	be be		Emily Moore	201		/ Bonni				altin		Md.2120
6 may	must	1	1X Buriel 2 Cremetion 3 4 Donation 5 Other (Specify)	Removal from State Cer	metery, crematory or	other place)		OA				
Page 6		Į į	21. SIGNATURE OF FUNERAL SERVICE	V	eadowr	idgeCem 22. NAME A	ND ADDRESS OF FA	(26/ CILITY	99 B	Altin	ore	Md.
BALT after death.	val.		P. Tur	M Conne	llu	300	elly Fu Mace Av	re.	Ralti	more	Md.	
ours aff	or removal		23. PART I. Enter the diseases shock, or heart fail	, or complications that ceusa ura list only one ceuse on a	d the death. Do	not enter the mo	oda of dying, auc	h aa ca	rdiec or respi	ratory arres	it,	Approximate interval Between
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the state	nt, #		disease or condition resulting in death)	a. CEREBROV DUE TO (OR AS	ASCUL	AR ACC	TUBGI					uks.
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E PE C		2	Nsturel 5 Pending	(Month, Day, Year)	IN	JURY WO	YES 2 NO					
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OR ATTEM	4.8	7	4 Nomicide determine		City)			C/ŋ	or Town, State)			
		7	29e. CERTIFIER 1 CERTIFYING F	PNYSICIAN: To the best of my know	rledge, desth occur	red at the time, data	and place, end due	to the co	use(e) end men	ner se stated		
THE HOSPITAL	filed within 72 PORTANT: If	OMPL		MINER: On the basis of exemination								d menner se stated,
E HOS	FTANT:	E CO	296, SIGNATURE AND TITLE OF CERT				29c. LICENSE NUI					onth, Day, Yeer)
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^	D =	2	30. NAME AND ADDRESS OF PERSON	N WNO COMPLETED CAUSE OF DE	ATN (ITEM 27) (Typ	e, Print)					-/	
0			DR. KENDALL FA	AULKNER 2300 I	DULANEY '	VALLEY R	D., TOWS	ON.	MD 212	204		
	1		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	IATURE							
	ì	- 4	APR 2 8 1995	Julia d'Euroseon Ran	rall							



BALTIMORE, MARYLAND 21215-0020	H hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hydiene prior to burial, cremation, or removal.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a focus after death. Page 6 may be retained by the hospital or attending physician.	O THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral he filed within 72 hours after death with the State Dept, of Health and Mental Hydlene prior to burfal, cremation, or removal.	DEPOTENT. If form 90 is sending as the 90 shows and later to after the bear made and the sending and the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sending as the sendin

	1 - STATE REGISTRAR	STATE OF MARYLA	AND / DEPARTI	MENT OF H	EALTH AND M	IENTAL HYGI				
Г	1. DECEDENT'S NAME (First, Middle, Last	Edythe Virgin				2. DATE OF DEATH		3. TIME OF DEATH  5.58 PM		
	4. SOCIAL SECURITY NUMBER	6. SEX 6. AGE (II	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year) Dec. 10	1.	. SIRTHPLACE (State or Foreign			
	212-12-4595 1 M 2 X F 75 YRS. MONTHS DAYS HOURS MIN.						, 1919	Maryland		
æ	aa. FACILITY NAME (If not institution, give				OR LOCATION OF DEA			Y OF DEATH		
6	UNION MEMORI	AL HOSPITAL	4	BALT	IMORE C	ITY		N/A		
DIRECTOR	10a. STATE 10b. COUNT			TOWN OR LOCAT				10d. INSIDE CITY		
	Maryland 100. STREET AND NUMBER	N/A	В	altimor				1XXYES 2 □ NO		
ERA	3208 Lake Aven	ue		101	Baltimore	21213		N OF WHAT COUNTRY? 21213 U. S. A.		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC	ENDENT OF HISPANI	C ORIGIN? (Specify	Yea or No- 14	I. RACE — American Indian.		
BY F	1 Never Married 2 Married 3 X Widowed 4 Divorced	FORCES? 1 TYES		If yes, sp	ecity_Cuban, Maxican, 2 NO Specify:	, Puarto Rican, etc.)	54 SACTIVE	Slack, White, etc.		
	16. DECEDENT'S ED	UCATION	18a. DECEDENT'S US	PILAL OCCUPATION	NA .	40. 2000 00	***************************************	White		
COMPLETED	(Specify only highest grad	(completed) College (1-4 or 5+)	(Give kind of work life. Do NOT use r	k done during mo retired.)	st of working	166. KIND OF	SUSINESS/INDUS	TRY		
MPL	12th Grade		Home	maker		Own	n Home			
	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NAM					
BE	Martin Joseph M.  19a. INFORMANT'S NAME (Type/Print)	cManus				n Isabel				
유	Mary Barnett (Da	aughter)			nd Number or Rural Rd Ct., Luth					
	20a METHOD OF DISPOSITION 1 Disposition 3 Ref		PLACEANDDATEOF				LOCATION — City			
	4 Donation 6 Other (Specify)	P.	arkwood C	r place)				re, Maryland		
	21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE 7.		22. NAME AN	on address of faci	LITY				
	MIMORE			3331	Brehms La	ane, Bali	timore,	Md. 21213		
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such se cardiac or respiratory arrest, shock, or heart failure. Liet only one cause on each line.  IMMEDIATE CAUSE (Final									
	disease or condition resulting in death)		Lmonia	2			Iweek			
		,	CONSEQUENCE OF):	,				1 YEAR		
O.	il Sequentially list conditions									
S	cause. Enter UNDERLYING CAUSE (Disease or Injury	· CONGE	STIVE H	EART	FAILUR	٤		1 week		
E	that initiated events resulting in deeth) LAST	DUE TO (OR AS A	CONSEQUENCE OF):							
CERTIFICATION		d								
CAL	PART II. Other algorificant condition	ne contributing to death bu	it not resulting in t	the underlying	ceuse given in P	art I. 24a. WAS	AN AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
MEDI	Pancyto	SKITICO				1 _ YES	2 NO	OMPLETION OF CAUSE OF DEATH?		
M.	DID TOBACCO USE CONT	RIBUTE TO CAUSE OF	DEATH VES	NO F	UNCERTAIN			1 _ YES 2 _ NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	2	6. PLACE OF DEATH		ONCERIAIN			L		
SIC	1 YES 2 NO	HOSPITAL: 1 Support 2 ER/Outpar		THER:	5 🗆 Residence 8	☐ Other (Specify)				
H	27. MANNER OF DEATH  1 Natural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	OF 28c. INJI	URY AT RK?	28d. DESCRIBE HOV	V INJURY OCCUR	ED		
BY	2 Accident Investigation	20- 81 405 05 11 11 19			ES 2 NO					
8	3 Suicide 8 Could not be 4 Homicide delarmined	28a. PLACE OF INJURY - building, etc. (Specif	— A1 nome, term, stre- (y)	et, factory, office	'	281. LOCATION (Streetly or Town, Sta		Rural Route Number,		
COMPLET	290. CERTIFIER 1 X CERTIFYING PHYS	SICIAN: To the best of my knowle	wine double comment	d the dies : de		2				
JWC	(Check only one) 2 MEDICAL EXAMIN	ER: On the besis of examination	and/or investigation, i	in my opinion, de	and place, and dua to eath occured at the til	o the cause(s) and r ma, data and placa.	and due to the e	ause(a) and manner as stated.		
	396. SIGNATURE AND TITLE OF CERTIFIE	9./	-		29c. LICENSE NUMS			IGNED (Month, Day, Year)		
O BE	Mary	ellehu MD						RIL 25, 1995		
5	30. NAME AND ADDRESS OF PERSON WI	HO COMPLETED CAUSE OF DEAT	TH (ITEM 27) (Type, Pri	int)		1/.				
	31 DATE FILED (Month Day Man)	Kellena		Mem	ORIAL	HOSPIT	AL			
	APR 2 8 1995	32. REGISTRAR'S SIGNAT	TUME							



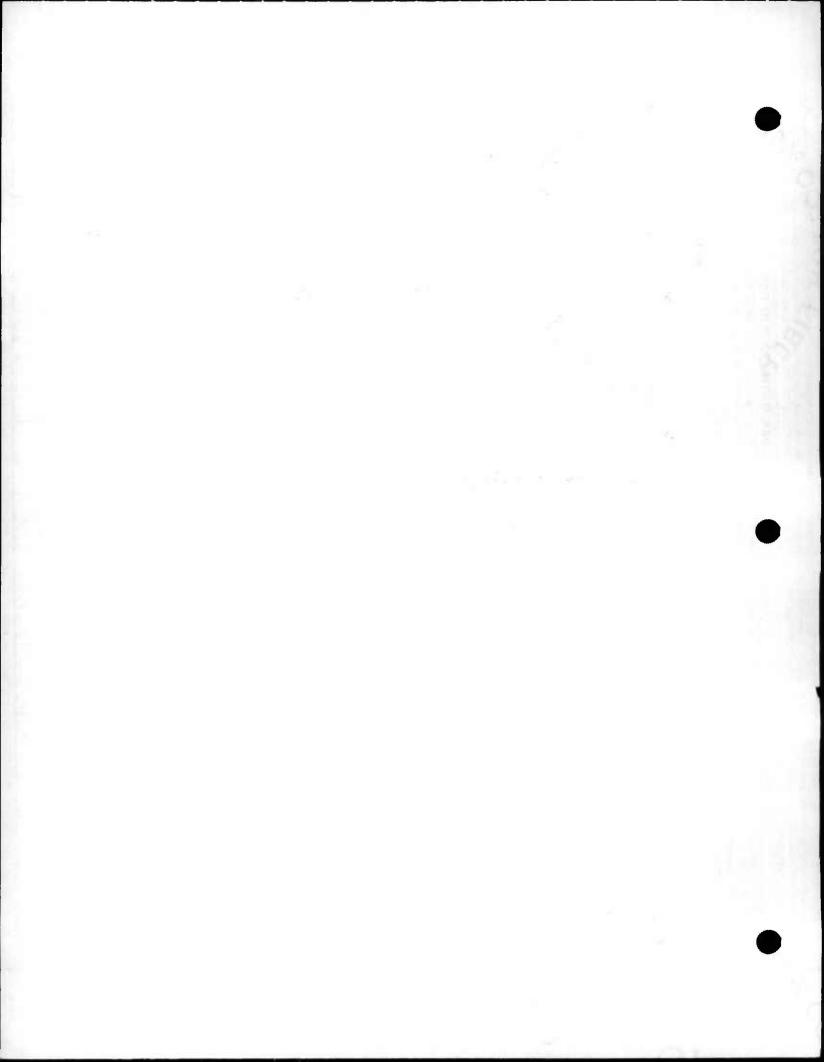
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DIVISION OF VITAL RECORDS, P.O. I	
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1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 2. DATE OF DEATH Mendenhall April 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTNPLACE (State or Formion OCT.11,1919 MARYLAND 212 36 8040 1 - M 2 X F 75 permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATN N/A DIRECTOR LIBERTY MEDICAL CENTER BALTIMORE RESIDENCE OF DECEDENT BALTIMORE 10d. INSIDE CITY MARYLAND N/A 1 YES 2 - NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? within 24 hours after death. Page 6 may be retained by the hospital or attending physician. npletely filled in by the funeral director, page 5 should be detached for use as the burial-transit 21217 U.S. OF A. 1610 N. FULTON AVENUE 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 TYES 2 KNO IF YES, GIVE WAR OR DATES 13. WAS OECENDENT OF NISPANIC ORIGIN? (Specify Yee or No—If yee, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married Specific BLACK B 3 Wildowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) n/a LAB TECHNICIAN STATE HOSPITAL 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) notified at ISAAC C. SMITH GEORGIA WATERS 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD . 21060 2 AMERICANNA CIR. APT 104 GLEN BURNIE, RUSSELL 9 20s. METNOD OF DISPOSITION
1 Burlet 2 Cremetion 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 3 🗆 R must MT. ZTON CEMETERY 5/1/95 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) LEWIS T. GWYNN 22. NAME AND ADDRESS OF FACILITY
LEWIS T. GWYNN FUNERAL HOME 21215 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Levynn ewis 4517 PARK HEIGHTSC AVE. BALTO., MD. filled in by the finn. or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line Interval Batwean 6 IMMEDIATE CAUSE (Finel Onset and Death the cremation, disease or condition resulting in death) Depsis 13 hvs completely traumatic event, DUE TO (OR AS A CONSEQUENCE OF): Renal Failure executed to burial, CERTIFICATION Sequentially list conditions DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted eventa resulting in death) LAST 6 Mental PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE 24s. WAS AN AUTOPSY by Failure Heart shows any 1 TYES 2 THO DF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATN (Check only one) Item HOSPITAL: OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Nome 5 Residence 8 Other (Specify) death with the S marked, or I 27. MANNGÉ OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. OESCRIBE NOW INJURY OCCURED 1 Natural 1 YES 2 NO After t BY 2 Accident 28e. PLACE OF INJURY — At home, farm, atreet, fectory, office building, atc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 50 8 Could not be hours after ( COMPLETED DIRECTOR: 4 Homicide 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated. TO THE HOSPITAL TO THE FUNERAL (De filed within 72 h 2 MEDICAL EXAMINER: On the nination end/or investigation, in my opinion, death occured at the time, date and placa, end due to the ceuse(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 04 13.65 BE April 26, 1995 2 38. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M George E Wicks 21215 Libert 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



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ATENDING PHYSICIAN: The law requires that the death certificate be executed within the found of the foundation of the hospital or attending physician.  CTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

1. DECEDENT'S NAME (First, Middle, Las	e) F		MAI	ONEY	,			2. DATE OF I	DA		YEAR	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. ia		IF UNDER		IF UNDER	3 94 1400	-	r 26	1 220		5:10 am
105-07-7369	1 🔀 M 2 🗌 F	80	YRS.	MONTHS	DAYS	HOURS	MIN:	7. DATE OF E (Month, De Apr 14	, 19	15	6. BIRTH Countr	W. Va.
9a. FACILITY NAME (If not institution, give Saint Joseph Me		9b. CITY, TOWN OR LOCATION OF TOWSON, ME										
10a. STATE 10b. COUN	ITY		10c. CIT	Y, TOWN O	R LOCA	TION						10d. INSIDE CITY
Md. Ba	ltimore				Tows	on						LIMITS?
10e. STREET AND NUMBER	TEIMOTE					1. ZIP COD	E			10g. CITI	ZEN OF V	WHAT COUNTRY?
611 Hillen Rd.						21	286				U.S	Δ
11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AI	RMED	13. V	NAS DEC	CENDENT (	OF HISPAI	VIC ORIGIN? (S	pecify Yes	or No—	14. RACE	- American Indian.
1 Never Married 2 Merried 3 Divorced	IF YES, GIVE W	YES 2 K	NO	1	yes, sp	ecify Cube	in, Mexica Specif	n, Puerto Ricar y:	i, etc.)	k, White, atc.		
				_								White
15. OECEDENT'S En (Specify only highest gra	OUCATION ide completed)	16a. Di	ECEDENT'S Give kind of v e. Do NOT us	VOR done of	CUPATI furing me	ON ost of working	ng	16b. KIN	O OF BUS	INESS/IND	USTRY	
Elementary/Secondary (0-12)	College (1-4 or 5 d	,						- 3	_	7		
17. FATHER'S NAME (First, Middle, Last)	4	Mec	hanic	al E	ngir	_			_	Ars	enal	
a localitate system.		M- 7						ME (First, Middle	_		T.T :	made and A
John Fra  19a. INFORMANT'S NAME (Type/Print)	ncis	Malone		100000	10.		anna		Agne			soloski
	Walassa							Route Number, C			Code)	
Mrs. Virginia S.	Maloney				_	_	wsor	n, Md.				
12 Buriel 2 Cremation 3 Re 4 Donation 6 Other (Specify)	moval from Stata	20b. PLACE cometery. cri Mt . M	ematory or of	her place)	TION (N	ama of	1	DATE /29/95		CATION —		wn, State
21. SIGNATURE OF LUMBRAL SURVICE	LICENSEE C	Pic. M	атта			ND ADDRE		1	100	2011	riu.	
11 6 1	DIA	)						Funera	1 Ho	me,	Inc.	
23. PAIT I. Enter the diseases, o			>					d. Tows				4
DUE TO (OR AS A CONSEQUENCE OF):  LEFT HEMOPHORAX  Sequentially list conditions, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initisted events resulting in death) LAST  PULMONARY EMBOLUS  OUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):									DAYS			
									DAYS			
PART II. Other algolificant condition  ATHEROSCLERO	reculting i	eulting in the undarlying couse given in Part i.					PERFORMED?			WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?		
DID TOBACCO USE CON	TRIBUTE TO CA	USE OF DEA	ATH YE	S   N	10 E	UNC	ERTAIN	10				1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HQSPITAL:	26. PLAC	CE OF DEAT	H (Check o	_							
1 TES 2 TO	1. Inpetient 2			4 🗆 Nursi		a 5 🗆 Ra	sidence	6 Other (Spe	ecify)			
7. MANNER OF DEATH  1 Netural 5 Pending 2 Accident Investigation	26a. DATE OF (Month, Da		26b. TIMI	E OF URY M		URY AT PRK? YES 2	] NO	26d. DEŞCRIB	E HOW IN	JURY OCC	UREO	
3 Suicide 6 Could not b determined	26e. PLACE O	F INJURY — At ho	ome, farm, s	draet, fecto	ry, offic	•		261. LOCATION (Street and Number or Rural Route Number, City or Town, State)				loute Number,
	SICIAN: To the best of NER: On the basis of ax											and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIC	HE WI	> Patt	Proli	ist			1543	IBER		29d. DATE	SIGNED 4	(Month, Day, Year) 543
STEVEN R. AXE, N	.D., ST. JO	SEPH M			NTE	FR, 76	20 Y	ORK AD.	WOT,	SON	MAR	YLAND 212
APR 2 8 1995	all alude	A SANATURE										

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STEVEN RIAKE MID. ST JUSSEHH MEDILAL CENTER 7820 YORK RD, TOWSON MAR JAND 2120

3. TIME OF DEATH

REG. NO

2. DATE OF DEATH

BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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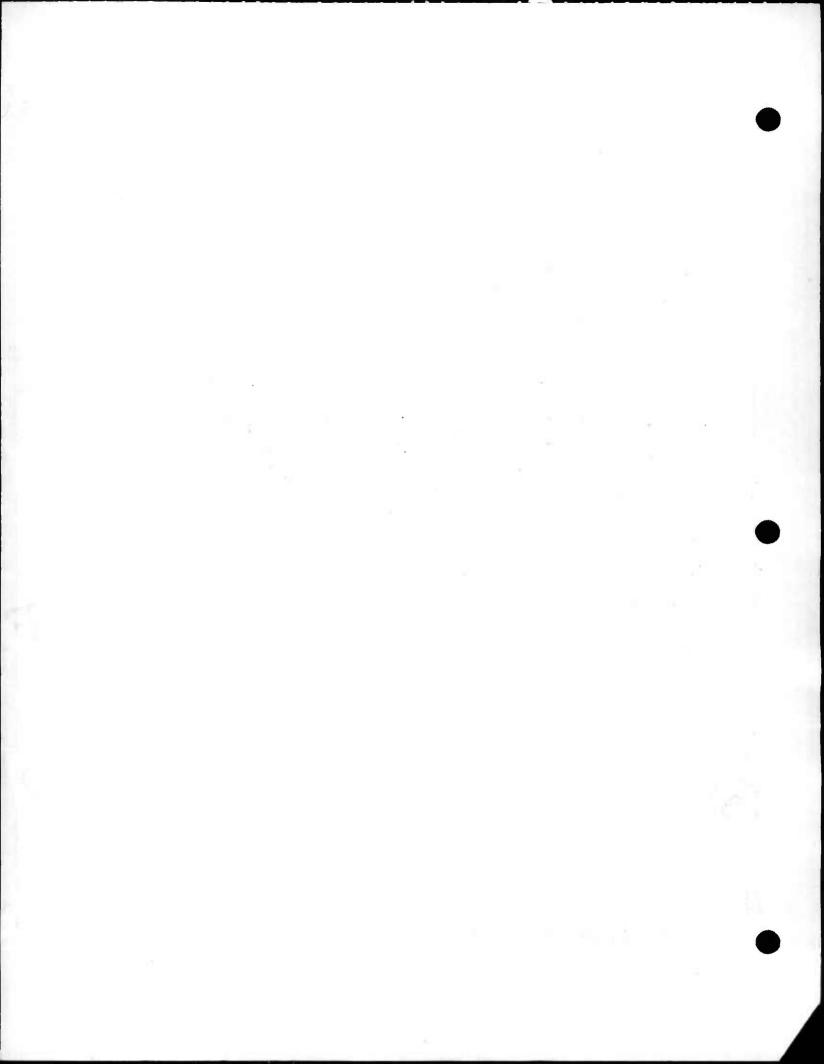
31. DATE FILED (Month, Day, Year)

APR 2 8 1995

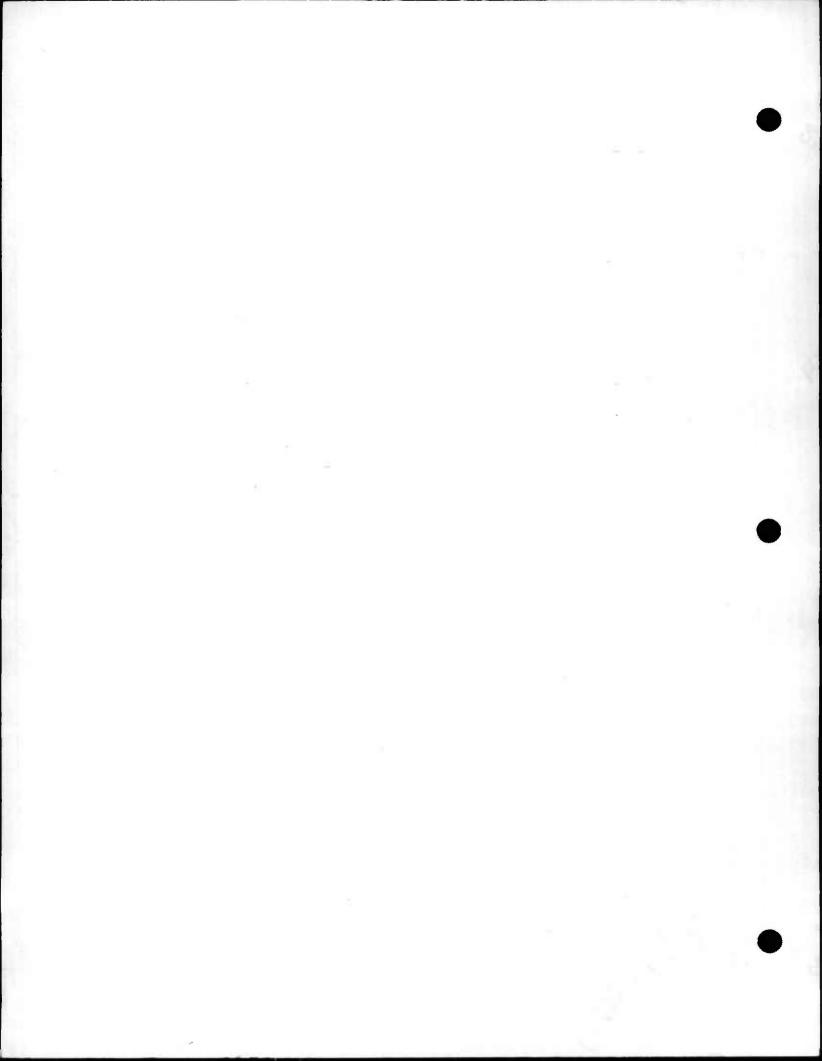
32 REGISTRAR'S SIGNATURE

MONTH 4 23 DENNIS NEWKIRK 1054 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 4/17/50 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS 1/1 M 2 | F 214 50 2392 YRS. 45 md. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR UNIVERSITY HOSPITAL BALTIMORE Pages 1, 2, 3 BALTO. CITY RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? BALTIMORE MD. BALTO. CITY 1 # YES 2 | NO permit. FUNERAL 10e STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 1307 W. SARATOGA ST. 21223 USA retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES! 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yas or No—
If yes, specify Cuban, Maxican, Puario Rican, atc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, While, alc. 1 Never Married 2 # Married В 3 Widowed 4 Divorced AFR. AMERICAN 15. DECEDENT'S EDUCATION E 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INOUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) ᆸ Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 N/A UNKNOWN UNKNOWN 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Sumame) te ALLEN M. NEWKIRK DORA LEE HALL BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 DORA LEE HALL 1307 W. SARATOGA ST. BALTO. MD. 21223 Page 6 may be þe 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must NATIONAL 4/28/95 LAUREL MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ESTEP BROS. FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217 In by the f removal. medicai 23. PART I. Enter the diseases, or complications that caused the seeth. Do not anter tha mode of dying, such as cerdiec or respiretory arrest, shock, or heart failure. List only one cause on each line. and completely filled in by burlal, cremation, or remo **Approximate** Interval Between IMMEDIATE CAUSE (Finel Onsat and Death the diseese or condition_ SEPSIS event. resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF): AMPE LIVER FAILURE traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to if any, leeding to immediate cause. Enter UNDERLYING signed by the attending physician Health and Mental Hygiene prior to CAUSE (Disease or Injury other 1 DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 0 PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO has been s DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) in this certificate ha in with the State D narked, or item Nem HOSPITAL: **EXAMINER?** OTHER: 1 | YES 2 | YES 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 - Nursing Home 5 - Rasidence 8 - Other (Specity) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Natural М 1 YES 2 NO BY __ Accident Investigation 28s. PLACE OF INJURY — At home, farm, atreet, factory, office 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 4 Homicide 29a. CERTIFIER COMPL 1 DEERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basia of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPIE TO THE FUNER DE filed WERR I 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Kn Mulus MD 4/23/95 1157 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KAKEN S. MACMURDY 225. Greene ST.

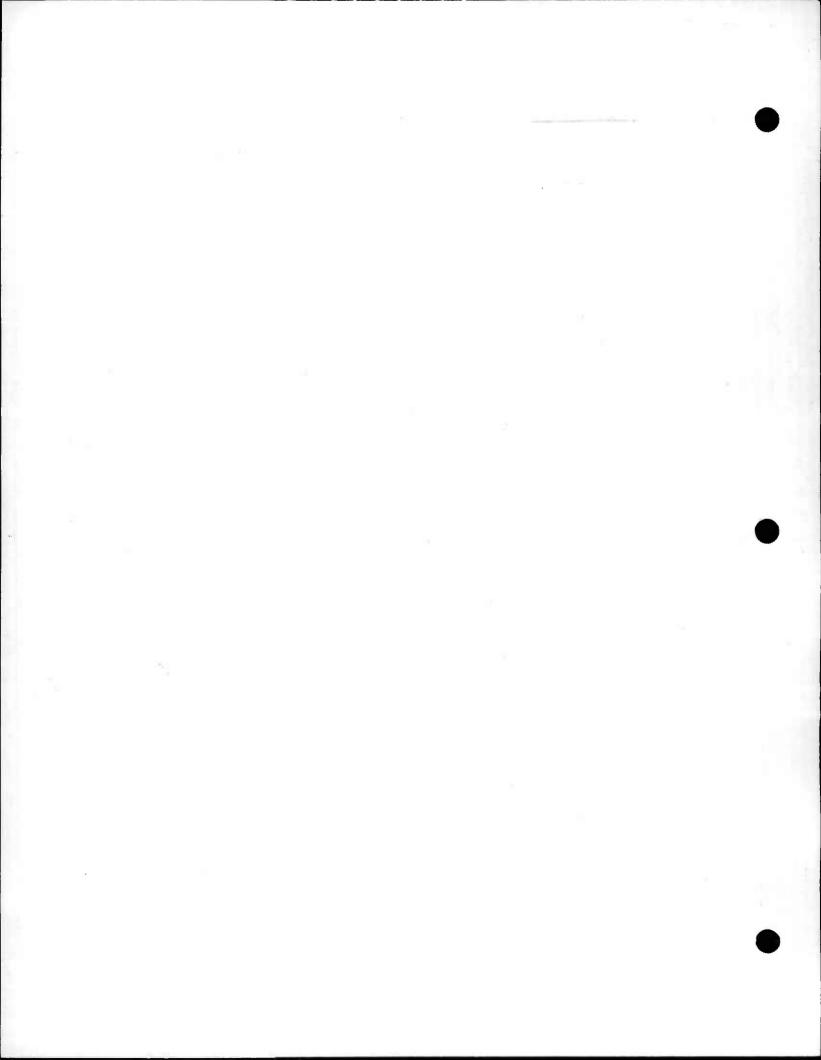
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



		1 - STATE REGISTRAR	SIAIL UF N	/ MAKYLAND CI				DEAT		MENTAL	REG. NO.	E		
		1. DECEDENT'S NAME (First, Middle, Lest)  2. DATE OF DEATH MANY VERN 3. TIME										TIME OF DEATH		
		Gatha Pauline	5. SEX	Phipps						Apri	1 24,	995	YEAR	8:00 P M
		4. SOCIAL SECURITY NUMBER  220 - 26 - 5865	6. AGE (In yrs. les	0.0	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN,	7. DATE O (Month),	F BIRTH Day, Year)		6. BIRTHPL Country)	ACE (State or Foreign	
pinc		9a. FACILITY NAME (If not institution, give st	82	YRS.	ah arr		R LOCATION			e 21,1	_		Virginia	
3 should	E C			,		96. CITY				EATH			t imox	
1, 2,	5	Franklin Square Hospital Rossville Baltimor									E			
Pages	DIRECTOR	Maryland 10b. county	Baltimor		10c. CI7	Y, TOWN (	OR LOCAT	ION	D	rdalk				Dd. INSIDE CITY
ermit.		10a. STREET AND NUMBER	Басланол	<u>.e</u>			101	. ZIP CODE		ruack		10g CITI		YES 2 NO
nsit p	ER/	4046 St. Augusti	ne Lane						212	222		109. CITIZEN OF WHAT COUNTRY?  United States		
215-0020 attending physician. se as the burial-transit permit. Pages	FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR		13.	WAS DEC	ENDENT O	F HISPAN	IC ORIGIN?	(Specify Yea		14, RACE	- American Indian, Vhita, atc.
21215-0020 al or attending physic for use as the burial.	BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W					2 □XNO		n, Puarto Ri v:	can, etc.)		Specify:	White
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LAND 21 the hospital or detached for u	COMPLETED	9 Years			Hou	us envi	be			_L		ı Hom	e	
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MARYLAND retained by the hospit 5 should be detached notified at once.	H	Lloyd B. Bennett  190. INFORMANT'S NAME (Type/Print)		101	MAILING	ADDRESS	2 /Stenot a			3. He	S.S. City or Town	0	0-10	
	2	Gatha L. Dembeck									imore,			3
BALTIMORE, I er deill. Page 6 may be the turners director, page 8 wal.		20g, METHOD OF DISPOSITION 1 M Buriel 2 Cremetion 3 Remo	wel from State	20b. PLACE	ND DATE	OF DISPOS	ITION /Na	me of		DATE	20c. LOC	ATION — C	ity or Town	State
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hours after ed in by the or removal medical		23. PART i. Enter the diseases, or c ahock, or heart failure.	omplicatione thet list only one ceu	t caused the de se on each line	ath. Do i	not enter	the mo	de of dyi	ng, sucl	h aa cerdi	ac or respir	etory arre	est,	Approximeta interval Between
Z = 2 = 2		iMMEDIATE CAUSE (Final disease or condition	Pnoumor	ni a										Onset and Death
3760 ted within 24 completely fille ial, cremation, event, the		disease or condition resulting in death)  Pneumonia  Due To (DR AS A CONSEQUENCE DF):  7 days											/ days	
BOX 68760 cate be executed with hysician and complete prior to burial, crem ar traumatic event	Z	Sequentially list conditions, 6. Aspiration 7 days												
OX 68 be executivities to buring the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purification of the purificat	ATIO	if any, leading to immediate cause. Enter UNDERLYING												
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AL RE s law requires been s Dept. of H		DID TOBACCO USE CONTR	IBUTE TO CA	USE OF DEA	TH YE	S 🗆 I	VO ⊠	UNC	ERTAIN	10			'	YES 2 NO
上年 皇皇 曹	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEA	TH (Check								
CTAN: entificant the St	IXSI	1 ☐ YES 2 😾 NO  27. MANNER OF DEATH	1 Inpatient 2 I				ing Home		aldenca	5 🗆 Other				
	PHY	1 🔯 Natural 5 🗌 Pending	28a. DATE OF (Month, Da		28b. TIM INJ	E OF URY	28c. INJE WOI		1 100	28d. DESC	RIBE HOW IN	JURY OCC	URED	
ON DING After death	BÝ	2 Accident Investigation 3 Suicide 6 Could not be	28a. PLACE OF	F INJURY — At ho	me, farm, i	street, fact		_	NO	281, LOCAT	ION (Street at	nd Number	or Rural Rout	a Number
DIVISION DR ATTENDING F DIRECTOR: After hours after death Item 28 is mar	TED	4 Homicide detarmined	building, a	atc. (Specify)						City or	Town, State)	, , , , , , , , , , , , , , , , , , , ,	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	, various,
DIV L DIREC L DIREC L DIREC L DIREC	COMPLET	29a. CERTIFIER (Check only 1 CERTIFYING PHYSIC	IAN: To the beat of	my knowledge, de	ith occurr	ed at the ti	me, data	and place,	and dua	to the caus	e(a) and man	oer an atate	d.	
TO THE HOSPITAL TO THE FUNERAL be filed within 72 th IMPORTANT: If I	Š.	one) 2 MEDICAL EXAMINER												nd manner as stated.
THE HO THE FU filed wii	H	29h SIGNATURE AND TITLE OF CENTIFIER	00	10		444		29c. LICE	NSE NUM	BER		29d. DATE	SIGNED (M	orith, Day, Year)
5 5 8 <b>M</b>	2	30. NAME AND ADDRESS OF PERSON WHO	July m	) /h	OD-	ceu		D4	149	18		14	124/	75
2		Dr. Randolph DeCa					e Dr	. Bal	Ltime	ore,	Maryla	and 2	1237	
)		APR 2 8 1995	32 REGISTRAF	R'S SIGNATURE										



		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMENT OF I	HEALTH AND	MENTAL HYGIEN					
		1. DECEDENT'S NAME (First, Middle, Last)				3. TIME OF DEATH						
		John Place	🛦 John Jos	eph Plac	cek Sr.				95 5.30 PM			
		4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country)			
pj	ERAL DIRECTOR	215-10-5356  Se. FACILITY NAME (If not institution, give stre	1 M 2 □ F   75	YRS.			Aug. 12,	1919	Maryland			
3 should						OR LOCATION OF D			Y OF DEATH			
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Pages		Marry Land N/A			TY, TOWN OR LOCA	TION			10d. INSIDE CITY LIMITS?			
permit. 1		Maryland N/A		Ba	altimore	1. ZIP CODE		1 X YES 2 NO				
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2121 al or atto for use	ED B	15. DECEDENT'S EDUCA	WWII	44- 0505054716					White			
		(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT u	S USUAL OCCUPATE work done during mo ise retired.)	ON ost of working	16b. KIND OF BL	JSINESS/INDUS	TRY			
	릴	10th grade	College (1-4 or 5+)	Painte	er		Bendi	x Corp.	•			
AND the hospite detached once.	COMPL	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maider	n Surname)				
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MARYLAND retained by the hospit 5 should be detached notified at once.	2	190. INFORMANT'S NAME (Type/Print)	(114 E - )				Route Number, City or Tox					
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Page 6 may at director, pag		1 N Buriel 2 Cremation 3 Removed Donation 5 Other (Specify)	ral from State	netery, crematory or of SEAD 1:	of disposition (Na other place) Slaus Cer				re, Maryland			
ALTIM death. Page funeral dire		21. SIGNATURE OF FUNERAL SERVICE SICE			22. NAME AI	ND ADDRESS OF FA	CILITY	are into	ic, naryrand			
BALTI er death. P. the funeral val. i examine		· 1111691					neral Home		W4 21212			
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>==		disease or condition resulting in death)  a. Respiratory abrest 5 min  DUE TO (OR AS A CONSEQUENCE OF):										
			DUE TO (OR AS A	CONSEQUENCE O	F):							
UX 68/1 e be executed sician and con rior to burial, traumatic en	O	Sequentisily list conditions, If any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the injury of the in										
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E Me e	L C	PART II. Other significent conditions	contributing to death b	ut npt resulting	In the underlying	g cause given in	Part I. 24s. WAS AF	N AUTOPSY	24b. WERE AUTOPSY FINDINGS			
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After death	D BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY	— Al home, lerm,			281. LOCATION (Street	and Number or I	Rural Route Number,			
DR ATTENDING PHYSICIAN: DIRECTOR: After this certifica hours after death with the St.	ш	4 Homicide determined	building, atc. (Spec	опу)			City or Town, State	)				
	COMPLET	29e. CERTIFIER 1 CERTIFYING PHYSICI	IAN: To the best of my knowl	ledge, death occurr	red at the time, date	end place, end due	to the cause(e) and me	nner as stated.				
THE HOSPITAL THE FUNERAL filed within 72 i	O.								euse(s) and manner ee stated.			
THE HOSPI THE FUNEF filed within	BE C	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUM	WBER	29d. DATE SI	IGNED (Month, Day, Year)			
5 5 3 M	0		ara, MD	_		AT 24	38946	<b>&gt;</b> 4	+   25/95			
8		30. NAME AND ADDRESS OF PERSON WHO Warel San	ara, M.O.		Union	Memo	38946 rial	Hosp	ital			
		APR 2 8 1995	32. REGISTRAR'S SIGNA	ATURE								
		ALIC DU 1000										



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

ours after death. Page 6 may be HOSPITAL OR ATTENDING PHYSICIAN: The law DIRECTOR: 2

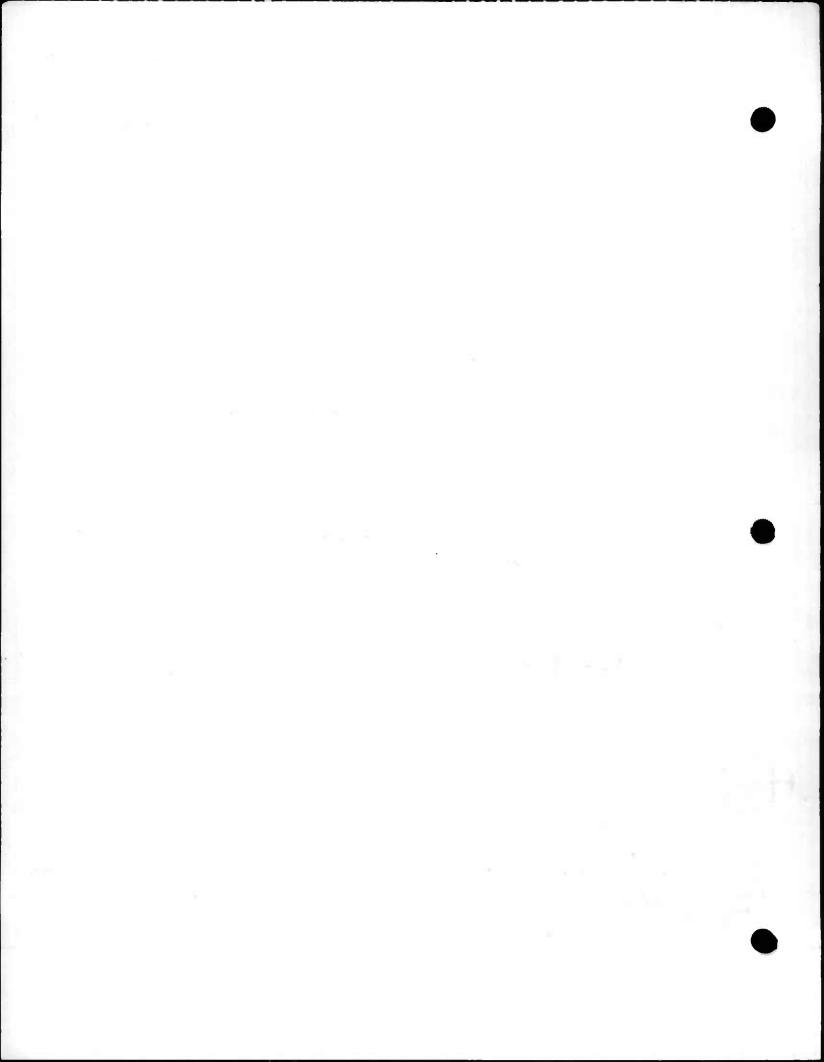
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF OEATH 3. TIME OF DEATH JOSEPH **JAMES** PASKO Oril 0815am 4 SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign HOURS 216-09-3079 1 X M 2 1 87 YRS -4-1908 Maryland Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH DIRECTOR Dorchester General Hospital Cambridge Dorchester RESIDENCE OF DECEDENT 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? Maryland Dorchester Hurlock 1 YES 2 XNO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6416 Suicide Bridge Rd use as the burial-transit 21643 USA retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuben, Mexicen, Puerto Ricen, atc.)
1 ☐ YES 2 ☑ NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married В Specify: 3 X Widowed 4 Divorced White 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high COMPLET funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or S+) Cooper Hurlock Pickeling Co. 17, FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surname) at Thomas Pasko Veronica Toma **BE** notifled 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Joseph T. Pasko 7812 Overhill Rd Glen Burnie, Md 21060 20s. METHOD OF DISPOSITION pe 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must Buriel 2 Cramation 3 Ramoval from State Donetton 5 - Other (Specify) Rosary Cemetery 14-29 Holv Baltimore, Md examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Dundalk 7110 Sollers Point Rd signed by the attending physician and completely filled in by the Health and Mental Hygiene prior to burial, cremation, or removal. the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. Liet only one cause on each line. Approximate Interval Retwe IMMEDIATE CAUSE (Finel Onset and Death disease or condition THE TO (OR AS A GASEQUENCE OF): BMED resulting in deeth) event. traumatic Vernoria CERTIFICATION Sequentielly list conditions. DUE TO (OR AS A CONSEQUENCE OF) if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): thet initiated eventa resulting in death) LAST 6 Injury, PART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE mell PERFORMED? any robert 1 - YES 2 NO OF DEATH? shows 1 TYES 2 NO t. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ PHYSICIAN: Dept 23 has I 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h with the State ( HOSPITAL: OTHER: 1 - YES 2 10 NO Inpetient 2 - ER/Outpatient 3 - DOA 10 4 - Nursing Home 5 - Residence 6 - Other (Specify) 28c. INJURY AT WORK? 27. MANNER OF DEATH 28a, DATE OF INJURY 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked. 1 Natural Pending Investigation After the 1 YES 2 NO В 2 Accident 28s. PLACE OF INJURY — At home, ferm, street, fectory, office building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 60 ETED 8 Could not be after 28 4 Homicide hours 2 item 29e. CERTIFIER COMPL CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(s) and manner as stated. TO THE FUNERAL D
be filed within 72 h
IMPORTANT: If it NER: On the besis of exemination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated. 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Mogth, Day, Year)

MPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

202 Collai



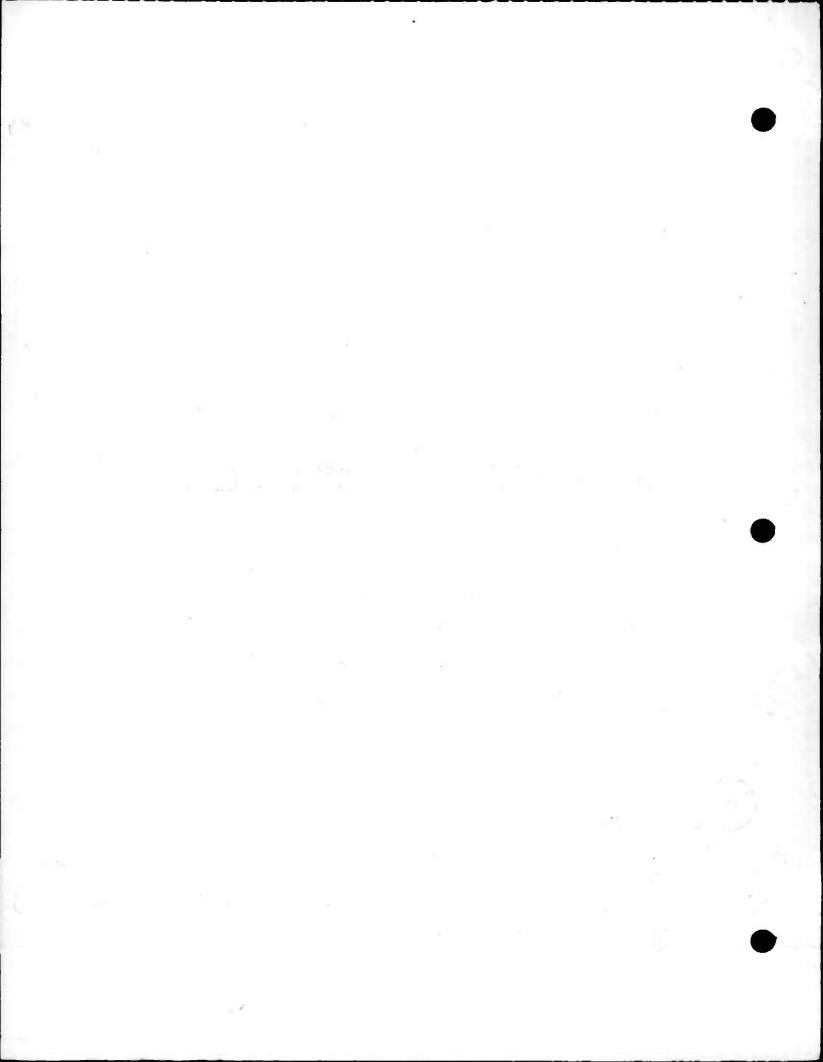
CORDS, P.O. BOX 68760, BALTIMORE, MARYLAN es that the death certificate be executed with	BALTIMORE, MARYLAND 21215-0020	be retained by the hospital or attending physicia
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ORDS, P.O. BOX 68760, s that the death certificate be executed with	_	ours after d
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DIVISION OF VITAL RECORDS, P.O. BOX 68760.

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TO THE MUSS III. OUR MANUAL PHYSICIAN: The law requires that the death certificate be executed with	TO THE FUNETAM INFECTED. We this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 st be filed within a first manual period of Health and Mental Hyriene prior to burial cremation or removal	IMPORTANT, a tem Zalas Listred, or item 23 shows any injury, or other traumatic event, the medical examiner must be noti

by the hospital or attending physician.	be detached for use as the burial-transit permit. Pages 1, 2, 3 should		
ay be retained	page 5 should		he potified
Lage o III	director,		mental or item 23 shows any injury or other fraumatic event the medical evaniner must be not
er Death.	ertificate has been signed by the attending physician and completely filled in by the funeral director,	al.	i avamir
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	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.											
	1. DECEDENT'S NAME (First, Middle, Last)	ETH A. RI	USS	ELL		2. DATE OF DEATH DAY		3. TIME OF DEATH				
	4. SOCIAL SECURITY NUMBER 214-20-2016	1 □ M 2X F 68	YRS.	ONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) MAY 16,19	26 MA	IRTHPLACE (State or Foreign ountry) ARYLAND				
TOR	98. FACILITY NAME (If not institution, give s LEVINDALE CONVALE RESIDENCE OF DECEDENT		9	BALTI	MORE	тн	9c. COUNTY C	ALTIMORE				
DIRECTOR	10a. STATE 10b. COUNT MARYLAND	BALTIMORE		TOWN OF LOCAT BALTIMO				10d. INSIDE CITY LIMITS? 1 YES 2 NO				
VERAL	100. STREET AND NUMBER 5512 CHANNING ROA	D		101.	21229		U.S.	A.				
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	S. ARMED	If yes, spe	ENDENT OF HISPANIC Helty Cuban, Maxican, 2 NO Specify	ORIGIN? (Specify Yes Puerto Rican, etc.)		NACE — American Indian, Black, White, atc. Specify: WHITE					
COMPLETED	15. DECEDENT'S EOU (Specify only highest grade Elementary/Secondary (0-12) 9TH GRADE	CATION 16s Completed) College (1-4 or 5 +)	Give kind of workite. Do NOT use r	k done during mo: retired.)	N st of working	16b. KIND OF BUS	MEMAKIN					
BE COM	17. FATHER'S NAME (First, Middle, Last) JOSEPH KARALFA		11011212		16. MOTHER'S NAME MARY D	E (First, Middle, Maiden S						
70	19a. INFORMANT'S NAME (Type/Print) HAROLD RUSSELL					BALTIMOR		21229				
Į.	20a. METHOD OF DISPOSITION  1 \( \sum_{\text{Burlet}} \) Burlet 2 \( \sum_{\text{Cremetlon}} \) Cremetlon 3 \( \sum_{\text{Rem}} \) Ram  4 \( \sum_{\text{Donation}} \) Donation 5 \( \sum_{\text{Other}} \) Other (Specify)	oval from State 20b. PLA cemetery LOU	ACE AND DATE OF I	disposition(Na r place) K CEMET	me of ERY		CATION — City of TIMORE	or Town, State				
	21. SIGNATURE OF FUNERAL SETUICE LIC	Coleman	·	HUBBAR		HOME INC		MD 21229				
CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, abock, or heart fellure. List only one cause on each line.  IMMEDIATE CAUSE (Finel disease or condition resulting in deeth)  Due to (on as a consequence of):  Due to (on as a consequence of):  Due to (on as a consequence of):  Due to (on as a consequence of):  Due to (on as a consequence of):  Due to (on as a consequence of):  Due to (on as a consequence of):  Due to (on as a consequence of):  Due to (on as a consequence of):											
MEDICAL	PART II. Other algorificent condition	egendant	Dio	Orlo	- Mall	PERFORI		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO				
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES NO		PLACE OF DEATH	(Check only one)	5 Residence 8							
BY PHYSICIAN:	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME C	OF 26c. INJU	JRY AT 2	26d. DESCRIBE HOW IN	JURY OCCURED					
E	3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF INJURY — A building, atc. (Specify)	At home, farm, atre	at, tectory, office	2	281, LOCATION (Street ar City or Town, State)	Street and Number or Rural Route Number, State)					
COMPL		CIAN: To the best of my knowledge R: On the basis of examination and						se(s) and manner as stated.				
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIES  30. NAME AND ADDRESS OF PERSON WH	7 3 6	(ITEM 27) (Type, Pri	_ rr _ ]	29c. LICENSE NUMBI	[682	29d. DATE SIGN	NED (Month, Day, May)				
	6717 Pa	le He	W.	SP	man	a (7	sold	0-21215				
	** ** APR 2 8 1995	32 REGISTRAR'S SIGNATUR	4									

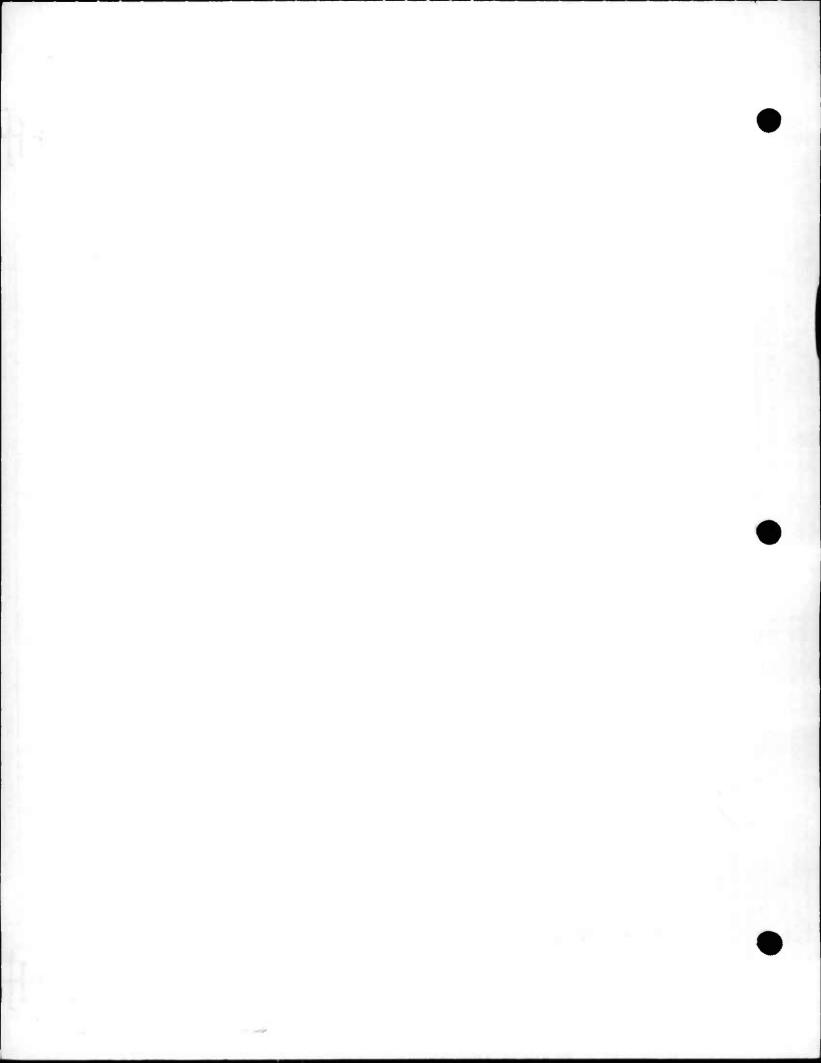


DIVISION OF VITAL RECORDS, P.O. BOX 68760

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL	HYGIENE
CERTIFICATE OF DEATH		REG. NO.

	1 - STATE REGISTRAR	STATE OF MARYLAN	ND / DEPART	MENT OF H	EALTH AND DEATH	MENTAL HYGIENE REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Lest) SYLVIA M. REED					2. DATE OF DEATH DAY APRIL 25,	1995	3. TIME OF DEATH 12:15 P M				
	220-10-4667	1 □ M 2 🕅 F 84	YRS.	F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) NOV . 22, 191	a DIDT	PLACE (State or Foreign				
TOR	98. FACILITY NAME (If not institution, give street 3526 ST. JAMES ROATESIDENCE OF DECEMENT		1		R LOCATION OF D	EATH	BALT	TIMORE				
DIRECTOR	10e. STATE 10b. COUNTY	THO D.T.	10c. CITY,	TOWN OR LOCAT				10d. INSIDE CITY				
	MARYLAND BALTI  100. STREET AND NUMBER	MURE			TIMORE ZIP CODE	1,	On CITIZEN OF	1 TYES 2 NO				
VER/	3526 ST. JAMES ROA	VD.			2120		U.S.					
BY FUNERAL	11. MARITAL STATUS 1 Naver Married 2 Married 3 Widowed 4 X Divorced	12. WAS DECEDENT EVER IN U. FORCES? 1 TYES IF YES, OIVE WAR OR DATE	2 XNO	If yes, spe	NOENT OF HISPA city Cuban, Maxico 2 NO Specia	NIC ORIOIN? (Specify Yaa or an, Puerto Rican, etc.)	Biac	E — American Indian, k, White, atc. WHITE				
TED	15. DECEDENT'S EDUCA (Specify only highest grade of	ompleted)	Give kind of wor	k done during mas	N t of working	16b. KIND OF BUSIN	ESS/INDUSTRY					
COMPLETED	Elementary/Secondary (0-12) 6TH GRADE	College (1-4 or 5 +)	LABORER			SEWING	FACTORY					
BE CO	17. FATHER'S NAME (First, Middle, Lest) HARRISON REED				FLODA	ME (First, Middle, Maiden Sur MALLOW						
5	19a. INFORMANT'S NAME (Type/Print) MARGARET SMOOT		196. MAILING A	OLLING	ROAD -	Route Number, City or Town, S BALTIMORE, M	State, Zip Code) D 2124	4				
1	20a. METHOD OF DISPOSITION 1 N Burlal 2 Cremation 3 Remov 4 Donation 8 Other (Specify)	al from State 20b.Pt.	ACE AND DATE OF	DISPOSITION (Ner	GARDEN	DATE 20c. LOCAT	ION — City or To					
	21. SIONATURE OF FUNERAL BERVICE LICEI		non	HUBBAH	ADDRESS OF FA	AL HOME INC.						
	23. PART I Enter the diseases, or con ahock, or heart fellurs. Li	mplications that caused that only one cause on each	ne deeth. Do not	enter the mod	le of dying, auc	AVENUE - BAT h ea cerdiec or reapirate	Dry arreat,	Approximate				
	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions.  Due to (or as a consequence of):  Due to (or as a consequence of):											
ATION	Sequentially list conditions, If any, leading to immediate cause, Enter UNDERLYING  DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO	ONSEQUENCE OF):									
	PART II. Other algnificant conditions	contributing to death but	not resulting in	the underlying	ceuse given in	Part I. 24a. WAS AN AUT		. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
PHYSICIAN: MEDICAL	1	ofte	saulti	rele	0	1 🗆 YES 2 🕃		COMPLETION OF CAUSE OF DEATH?				
N: M	DID TOBACCO USE CONTRI		DEATH YES	D NO D	UNCERTAI	<u> </u>		1 WES 2 NO				
CIAI	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH									
HYSI	1 YES 2 NO 1	28s. DATE OF INJURY	ont 3 DOA 4	☐ Nursing Home		8 Other (Specify)						
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR	Y WOF	ES 2 NO	28d. OEŞCRIBE HOW INJU	RY OCCURED					
	3 Suicide 8 Could not be detarmined	28a. PLACE OF INJURY — building, etc. (Specify)	At home, farm, stre	et, factory, offica		281. LOCATION (Street and City or Town, State)	Number or Rural F	Route Number,				
COMPLETED		AN: To the best of my knowledg On the beals of axamination ar						) and manner as stated.				
TO BE	296. SIGNATURE AND TITLE OF CERTIFIER	ja			29c. LICENSE NUI	25 I	d. DATE SIGNED	(Month, Day, Year)				
۲	DR. TAHOORA KAWA T	COMPLETED CAUSE OF GEATH	COLLINE TO	int)	4 1 Y 2							
	DR. TAHOORA KAWAJ	I 32. REGISTRAR'S SIGNATU	IRE	OAD - R	ANDALLSI	OWN, MD 21	133					
	APR 2 8 1995 yu	in attavolver hards	Щ									

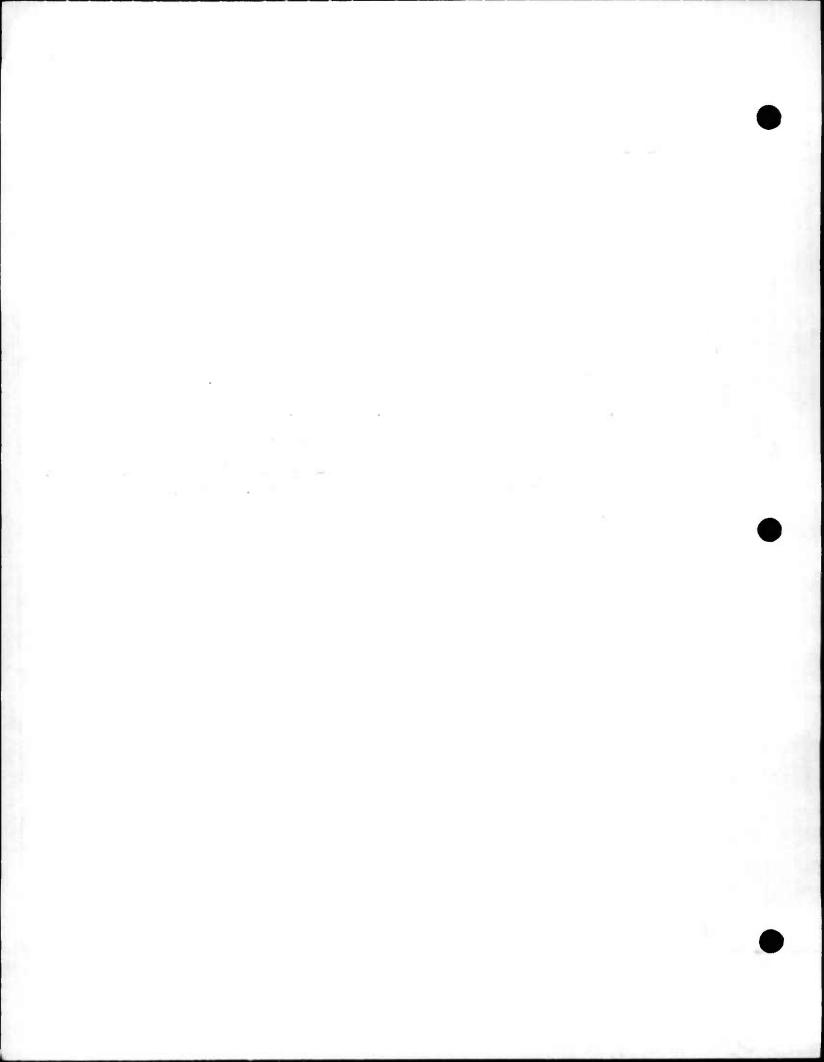


hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 - STATE REGISTRAR

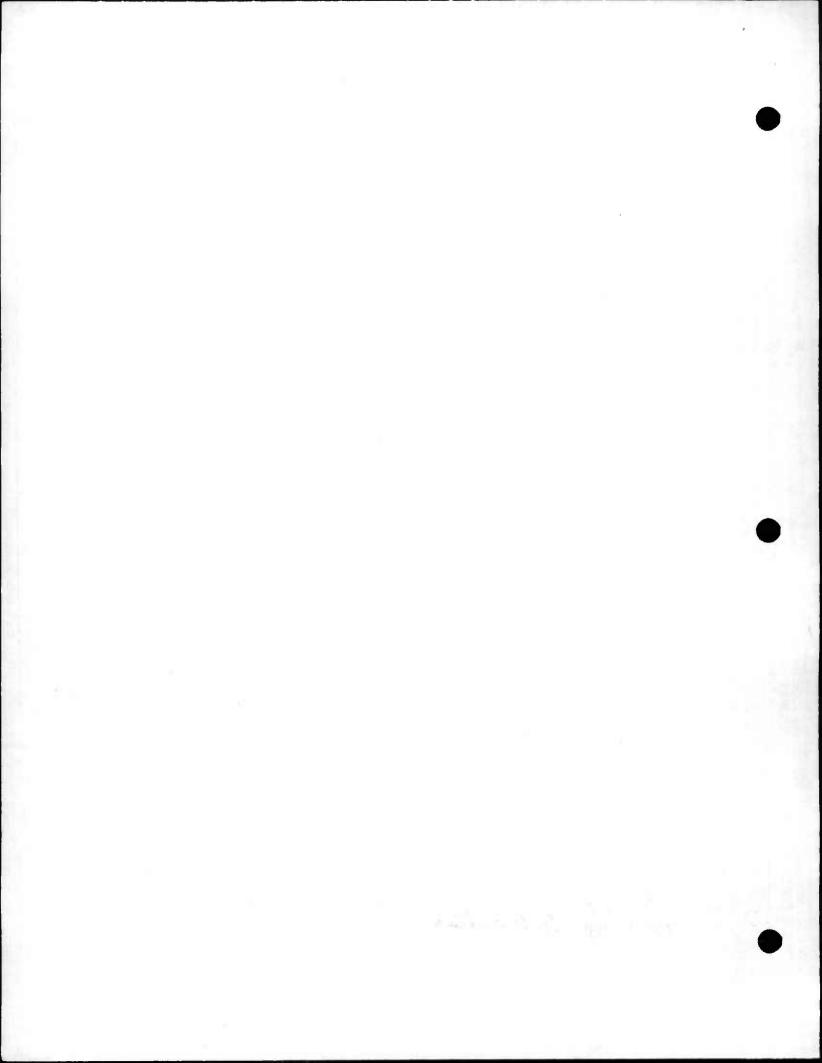
## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		TIEGIOTTATI				CL	-INIIII	IVALI	= Or	DEA	ıп		REG. NO.				
		1. DECEDENT'S NAME (First, Middle, Last)  2. DATE OF DEATH MONTH  MARY ANN RUSh  2. DATE OF DEATH MONTH  April 8 10 1005  7.200 A.											_				
												Ax	ril 10	199	5	7:20 A	M
		4. SOCIAL SECURITY NUMBER 214-30-4324		5. SEX	11	(In yrs. les	- 11	IF UNDER	DAYS	IF UNDER	MIN.	7. DAT	E OF BIRTH		8. BIRTHPL	ACE (State or Foreign	_
Pin		99. FACILITY NAME (# not in				78	YRS.							sylvania			
3 should	æ	20 South													TY OF DEAT	гн	
. 2	DIRECTOR	RESIDENCE OF DEC		soleer				מ	uu	more	Cit.	y		N	/A		
Ses	l ñ	10a. STATE	10b. COUNTY	r			10c. CIT	Y, TOWN	OR LOCA	TION					10	d. INSIDE CITY	-
permit. Pages		Maryland		Baltin	nore					1	Dund	alk			1	LIMITS?	
perm	¥	104. STREET AND NUMBER							10	r, ZIP COD				10g. CITIZ	EN OF WHA	AT COUNTRY?	_
ansit	買	515 48th S	treet								Z	1224		Un	ited	States	
physician. bunal-transit	FUNERAL	11. MARITAL STATUS 1 Never Married 2	Married	12. WAS DECEDEN FORCES? 1				13.	WAS DE	CENDENT C	OF HISPAN	VIC ORIG	IN? (Specify Yes Rican, etc.)	or No-	14. RACE Black, V	American Indien, Vhite, stc.	Ī
	B	3 Widowed 4 Divo		IF YES, GIVE Y	MAR OR D	ATES				2 □XNO			, , , , , , , , , , , , , , , , , , , ,		Specify:	White	
attending se as the	B		EDENT'S EDU			18e. DE	CEDENT'S	USUAL O	CCUPATI	ON		16	b. KIND OF BUS	INESS/INDI	ISTOV	writte	
6	E	(Specify onl) Elementary/Secondary (0	highest grade	completed) College (1-4 or 5	4)	(Gi	ve kind of a Do NOT us	work done se retired.)	during m	ost of working	ng	"	D. KIND OF BOO	INESSTIND	TOTAL		
Spita hed f	릴	Unknown	-,		• ,	Lie	cens	ed Pr	iact	ical	Nur	se	Heal	th Ca	re Pr	ovider	
by the hospital be detached to at once.	COMPLET	17. FATHER'S NAME (First, M.	iddle, Last)							18. MOT	HER'S NA	ME (First,	Middle, Meiden	Sumame)			-
> 2 %	ш	Hull Coate	S								S	usan	H. Unl	enown			
5 should b	TO B	190. INFORMANT'S NAME (7)				19b	MAJLING	ADDRESS	(Street	end Number	or Rural I	Route Nur	mber, City or Town	, State, Zip	Code)		_
y be re page 5 be no	-	David P. R					20 5	s. Cu	vrle	y St.	. Bo	alti	more, 1	ND 2	1224		
E S to		20g. METHOD OF DISPOSITI	n 3 🗆 Reme	oval from State	200	PLACE A	NDDATE	OF DISPOS	ITION //	nme of		DA	TE 20c LO	CATION - C	ity or Town	State	_
Page 6 I directo		4 Donation 5 Other (Specify) Baltimore, MD												MD			
death. Pag tuneral dir I. examiner		22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc.															
0 4 6		Reg	on 1	E. 100	·×	_							undalk				
nours after d d in by the or removal.		23. PART I. Enter the di	season or c	complications the	t cause	d the da	nth. Do r	ot enter	the mo	de of dy	ing, suci	h as ca	rdiac or respin	atory arre	et,	Approximata	_
DO DO E		IMMEDIATE CAUSE (Fin		List only one cet	ISO ON E	ecn line.										Onset and Desti	
tely fille mation,		disease or condition resulting in death)	<b>+</b>	a. Bre	407	+ 6	and	cer	_							weknow	
ompleteh di, crema event,				DUE TO	(OR AS	CONSEC	UENCE O	F):									_
executed within and completely filled to burial, cremation, matic event, the	8	Sequentieily list conditi	ons.	b	-20 TH												
ertificate be execute ng physician and co giene prior to buria	CERTIFICATION	if any, leading to immed cause. Enter UNDERLY!	liate	DUE TO	(OR AS A	CONSEC	UENCE OI	F):									
leath certificate be attending physician mal Hygiene prior try, or other traur	윤	CAUSE (Disease or inju- that initiated events		DUE TO	(OR AS A	CONSEO	UENCE OF										_
th certi ending I Hygie or oth	E	resulting in death) LAS	г					,.								j	
e death certificathe attending phase Mental Hygiene ljury, or other	빙			J								_					-
두 등 등	MEDICAL	PART il. Other significe				ut not re	auiting	in the un	deriyin	g cause g	lven in	Part i.	24a. WAS AN / PERFORI			RE AUTOPSY FINDINGS	Ī
signed I signed I Health a	음	Cerebrova	scular	Acciden	τ								1 TES 2		co	MPLETION OF CAUSE DEATH?	
requires seen sign of Healt	Z Z	_ASCVD														YES 2 NO	
has been Dept. of n 23 sho	ä		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \( \square\) NO \( \square\) UNCERTAIN \( \square\)														
V: The cate h	PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:		26. PLACI	OF DEAT	OTHER									_
SICIAN: The certificate h the State d, or Item	IYS	1 TYES 2 NO		1 Inpatient 2 I		entient 3	1	4 🗆 Nun	ing Hom	10 5 № Re	aldence						
His With			Pending	(Month, D			26b. TIM INJ	URY M	WC	URY AT	7	28d. DE	SCRIBE HOW IN	JURY OCCU	JRED		
After Adeath death	ВУ	2 Deutste	nvestigation	28e. PLACE O	F INJURY	- At bon	ne lerm r			YES 2	NO	001.10	CATIONI (Cr	440			
L OR ATTENDING P. DIRECTOR: After thours after death item 28 is mark	TED		Could not be letermined	building,	etc. (Spec	elfy)		Areet, lect	ory, ome			C/h	CATION (Street as or Town, State)	nd Number o	r Rural Route	Number,	
DIRECT HOURS	ш	29a. CERTIFIER															
보 보이는	COMPL			CIAN: To the best of													
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT; II	8				CALLIN HALLO	II enu/or ii	ivestigatio	n, in my o	pinion, e	eeth occun	ed at the	time, det	e end place, end	due to the	ceuse(s) en	d menner as stated.	
HE HE	BE	29b. SIGNATURE AND TITLE	-	Utfet	10					29c. LICE	NSE NUM	IBER		29d. DATE	SIGNED (Mo	onth, Day, Year)	
2 2 2 ₹	2	30. NAME AND ADDRESS OF				ATIL OTES	AT (7	0.1.0		p	901	1/6	)	7	1101	75	
		Tammi- O	15-1	1xxx	II A	910	SA	ZTINE)	Un'	Sa	) d	DA	LETT ON	a R	141.	1021237	
		31. DATE FILED (Month, Day, 1)	bar)	32. REGISTRA						4				110	un	240/	_
	4	APR 2 8 1995	5 July	i devolu	Rus	. 11											
					- /												- 1



DS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within = 5 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: if Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death or	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funera be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last) ZORA D.		HOALS	2. DATE OF DEATH DATE OF PRICE	YEAR	3. TIME OF DEATH					
		(In yrs. lest birthday)	IF UNDER 1 YEAR IF UNDER 24 HR MONTHS DAYS HOURS MIN		8. BIRT Cour	INPLACE (State or Foreign ntry)					
	224-60-6249 1 □ M 2 🖾 F 8  9a. FACILITY NAME (if not institution, give street and number)	35 YRS.	- A'   III   - 12.	1909	Kansas						
œ	Northwest Hospital Center		9b. CITY, TOWN OR LOCATION OF		9c. COUNTY OF						
16	RESIDENCE OF DECEDENT		Randallstown	1	Balti	lmore					
DIRECTOR	10a. STATE 10b. COUNTY	10c. Ci1	TY, TOWN OR LOCATION			10d. INSIDE CITY LIMITS?					
	Maryland Baltimore		Baltimore			1 TES 2 NO					
FUNERAL	10e. STREET AND NUMBER		10f. ZIP COOE		10g. CITIZEN OF	WHAT COUNTRY?					
NE I	3513 Keston Road  11. MARITAL STATUS  12. WAS DECEDENT EVER #	NII C ADMED	21207		U.S.						
BY FL	1 Never Married 2 Married FORCES? 1 YES 3 Widowed 4 Divorced FYES, GIVE WAR OR D	2 X NO	t3. WAS DECENDENT OF HIS tf yes, specify Cuban, Mai 1 ☐ YES 2 🖾 NO Sp	rican, Puerto Rican, atc.)	Ble Spe	CE — American Indian, ck, White, atc.					
	15. DECEDENT'S EQUICATION	16e DECEDENT'S	USUAL OCCUPATION	16b, KIND OF BUS		White					
	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 6 +)	(Give kind of life. Do NOT u	work done during most of working	IOD. KIND OF BUS	INCSS/INDUSTRT						
릴	Unknown	Acco	untant	U.S.G	overnmen	rt.					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		16. MOTHER'S	NAME (First, Middle, Maiden							
BE (	James A. Gafford		An	anda	Ochampa	iugh					
2	19e. INFORMANT'S NAME (Type/Print)		AODRESS (Street and Number or Ru		n, State, Zip Code)						
	Mr. Dana F. Sheild			ltimore, MD	21207						
	20s. METNOO OF OISPOSITION 1 ST Burlel 2 ☐ Crematton 3 ☐ Removal from State 4 ☐ Oonation 6 ☐ Other (Specify)	netery, crematory or c	of disposition (Name of Other plece) Memorial Park	1 .	CATION — City or						
1 1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	ational .	22. NAME AND AGORESS OF		1s Chur	ch, VA					
	Stephen M Jankins		Loring Byers 8728 Liberty	Funeral Di							
	23. PART I. Enter the diseases, or complications that cause	d the desth. Do	not enter the mode of dying, a	uch ea cerdiac or reepi	ratory erreet,	Approximete					
	ahock, or heert feliure. List only one cause on each line.  IMMEDIATE CAUSE (Finel disease or condition resulting in deeth)  - ACUTE MI  - CHET TO OR As A CONSTRUCTOR										
CERTIFICATION	Sequentielly liet conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST  OUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):										
CALC	PART II. Other aignificent conditions contributing to deeth b	out not resulting	in the underlying ceuse given			b. WERE AUTOPSY FINGINGS					
				PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE					
MEDI						OF DEATH?					
	DID TOBACCO USE CONTRIBUTE TO CAUSE O	F DEATH YE	ES NO UNCERTA	MIN DE	L						
SICIAN:	EXAMINER? HOSPITAL:	26. PLACE OF DEA	TH (Check only one) OTHER:	7							
×S	1 YES 2 700 1 74 Postlant 2 ER/Outs		4 Nursing Home 5 Realden								
ву рну	27. MANNER OF DEATH  1 Plantural 5 Pending 2 Accident Investigation	26b. TiM	IE OF 28c. INJURY AT WORK?  M 1 YES 2 NO	26d. DESCRIBE NOW IN	JURY OCCURED						
G	3 Suicide 8 Could not be detarmined 28a. PLACE OF INJURY building, atc. (Special Could not be detarmined)	— At home, ferm,	street, factory, office	26f. LOCATION (Street a City or Town, State)	nd Number or Rural	Route Number,					
COMPLET	29a. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my know 2 MEDICAL EXAMINER: On the basis of examination					(e) and manner ea stated.					
띪	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE I	1UMBER 7333	29d. DATE SIGNE  ▶ APA	O (Month, Day, Year)					
10	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE	ATN (ITEM 27) (Type	Print) MO?	1127.	7 1 1	, ,					
	APR 2 8 1995	TYPE	10- 101/2	1173							
	AFR 6 0 1333	1									



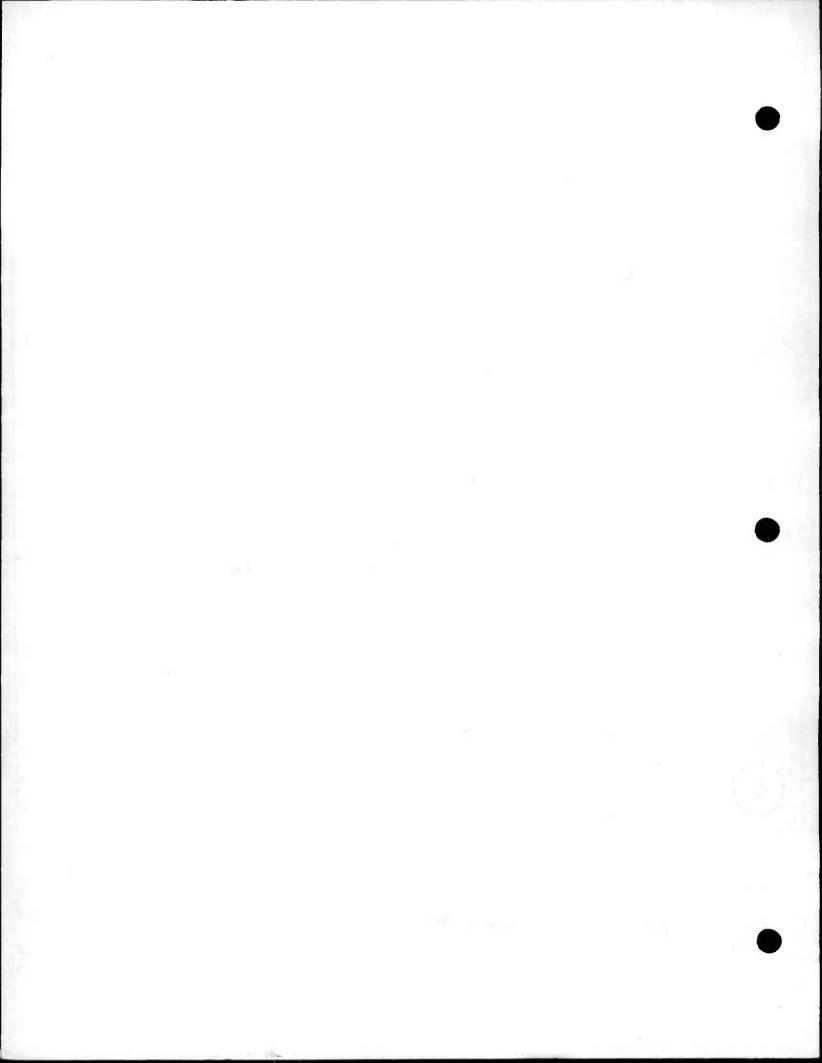
	_	1 - STATE REGISTRAR	SIAIE UF N	MAKTI	CERTI					MENTAL HY(	I NO.		
		1. DECEDENT'S NAME (First, Middle	_							2. DATE OF DEA		YEAR	3. TIME OF DEATN
		Frederick  4. SOCIAL SECURITY NUMBER	D.		Robinsor	_				April	25,	1995	8:30 P M
		216-18-583	5. SEX 1	6. AGE	73 YRS.	MONTHS	DAYS	HOURS	24 HRS. MIN.	7. DATE OF BIRT	er)	8. BIRTI Count	
pinous		9a. FACILITY NAME (If not institution			75	9b. CIT	Y, TOWN (	OR LOCATI	ON OF DE	10-20-		COUNTY OF D	VA.
2, 3 si	CTOR	MARYLAND GEN		TA:	L			10RE			100	V/A	
	EG		COUNTY		10c. C	ITY, TOWN	OR LOCAT	TION					10d. INSIDE CITY
it. Pages	DIRE	MD. N	/A		B	ALTI	MORI	Ξ					LIMITS?
permit.	\¥	10e. STREET AND NUMBER			101	. ZIP CODI			10g.	CITIZEN OF	WHAT COUNTRY?		
physician. burial-transit	FUNERAL	2221 BRUNT						212				US.	Α
ooco		1 Never Merried 2 Marrie	12. WAS DECEDENT FORCES?	YES	2 NO	13.	if yes, sp	ecify Cuba	n, Maxicai	IIC ORIGIN? (Spec n, Puarto Rican, el	lfy Yea or No C.)	- 14. RAC Blac	E — American Indian, k, White, atc.
	ВУ	3 Widowed 4 Divorced	TP YES, GIVE W	IF YES, GIVE WAR OR DATES			1 U YES	2√□ NO	Specify			Spec	BLACK
or attendi	TED	15. DECEDENT (Specify only highes	S EDUCATION If grade completed)		18a. DECEDENT (Give kind of life. Do NOT	work done	during mo	ON ost of workin	10	16b. KIND C	F BUSINESS	S/INDUSTRY	
spital or ed for u	PLE	Elementary/Secondary (0-12) 6th	College (1-4 or 5 +	-)	LABOI					DEP	r. OF	אווק ד	. WORKS
the hospital or attending a detached for use as the once.	COMPLET	17. FATNER'S NAME (First, Middle, L	est)		L Biibo.	\DI\		18. MOTI	NER'S NAI	ME (First, Middle, N			· WORKE
# & &	100	JOE ROBI						LE	NER	SPELLI	MAN		
retained 5 should notified	TO E	19a. INFORMANT'S NAME (Type/Prin								loute Number, City			0.1010
		FREDERICK D	• GLASS	200						IN. AP			O MD,@!212
. Page 6 may be ral director, page		1 Surial 2 Cremetion 3 4 Donation 8 Other (Specific		S S	Carriso	n For	ost	Vet.	Cem	1		N — City or To	wm, Stata ngs Mills, M
death. Page 6 m funeral director,		21. SIGNATURE OF FUNERAL SERV	ICE LICENSEE	1		_		O ADDRES		1	2712112		g, ·-
9 7		1		-						WYLIE	-		
E 3 5		23. PART I. Enter the disease	s, or complications thet	ceuse	d the deeth. Do	not ente	the mo	de of dyl	ng, such	MOR STI	respiratory	y srrest,	Approximate
		IMMEDIATE CAUSE (Finel	llure. List only one csu	se on e	ech line.								Interval Between Onset and Death
		disease or condition resulting in death)	Ruptur				ic A	neur	sym				unknown
B 2 - 9	_		DUE TO	(SA RO)	A CONSEQUENCE	OF):							
	ERTIFICATION	Sequentially list conditions, if any, leading to immediate	b	(OR AS	A CONSEQUENCE	OF):							
ficate be physician ne prior t	CA	cause. Enter UNDERLYING CAUSE (Disesse or Injury	۵										
death certificate attending physiemal Hygiene pri		that initiated events resulting in death) LAST	DUE TO	(OR AS	A CONSEQUENCE	OF):							
he death certif the attending Mental Hygier Ijury, or oth	빙	7, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3,	d	-	-								
ind of the	Ä	PART II. Other significent con	ditione contributing to	deeth b	out not resulting	In the u	nderlying	cause g	lven in i	Part I. 24a. W	S AN AUTOF		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
res that igned by ealth an	MEDIC/									— X□ Y	ES 2 NO	,	COMPLETION OF CAUSE OF DEATH?
he law requires has been signe Dept. of Healting 23 shows	W	DID TOBACCO USE CO	ONTRIBLITE TO CAL	LISE C	DE DEATH V	EC []	NO F	LUNC	ERTAIN				YES 2 NO
he law e has b e Dept. m 23	SICIAN:	25. WAS CASE REFERRED TO MEDI-		035 0	26. PLACE OF DE			DIAC	EKIAIN	(П)			
SICIAN: The certificate h the State h, or item	SIC	EXAMINER?	HOSPITAL:	ER/Out	patient 3 DOA	OTHE 4 Nu		e 5 🗌 Re	sidence (	6 Other (Specify	)		
PHYSICIAN: The this certificate his with the State or with the state or when the them	РНУ	27. MANNER OF DEATH  1 Natural 5 Pending	26a. DATE OF (Month, Da		28b. Ti	ME OF	28c. INJ WO	URY AT RK?		26d. DESCRIBE N	IOW INJURY	OCCURED	
DING PHYS After this death with	B	2 Accident Investig	ation	E IM ILLEN	/ At home form	M		rES 2	NO NO				
City or Town, State)										treet and Nui State)	mber or Rural F	loute Number,	
Check only one)  2   MEDICAL EXAMINER: On the beals of axaminstion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.  20   MEDICAL EXAMINER: On the beals of axaminstion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and representation and one of axaminstion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and representation and one of axaminstion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.											) and manner as stated.		
5 5 5 M	TO B		O The pring					89	227				27,1995
, 1		30. NAME AND ADDRESS OF PERSO Suhail Abba	Si, M.D. C/	O M	ATH (ITEM 27) (Tyr	e, Print)	-21 L	loen:	+01		•		
4		31. DATE FILED (Month, Day, Year)				OCT IC!	ar r	roshr	Lal			_	
		APR 2 8 1995	July Davelson	Car	Sall								

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SION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	REGISTRAR		U	ERITE	ICALE	: OF	DEA	H	REG. NO	),			
1	1. DECEDENT'S NAME (First, Middle, Last)  JOHN MARSHALL	SHEETS,	JR.						2. DATE OF OEATH MONTH APRIL 24	MY 199	YEAR	3. TIME OF DEATH 16:12 P M	
	4. SOCIAL SECURITY NUMBER	st birthday)						177.					
	213-50-6804	5. SEX	44	YRS.	MONTHS	DAYS	HOURS	MIN,	7. DATE OF BIRTN (Month, Day, Year) NOV . 30, 19	50	Counti	PLACE (State or Foreign Y) RYLAND	
	9e. FACILITY NAME (If not institution, give st	reet and number)			9h. CITY	TOWN C	OR LOCATION	ON OF DE			NTY OF D		
5	ST. AGNES HOSPITA				96. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				AIN .			ORE CITY	
DIRECTOR	RESIDENCE OF DECEDENT												
#	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN O	R LOCAT	ION					10d. INSIDE CITY LIMITS?	
		IMORE				В	ALTI	10RE				1 WES 2 NO	
₹I	10e. STREET AND NUMBER					101	. ZIP CODE			10g. CITI	ZEN OF V	VHAT COUNTRY?	
FUNERAL	3001 FREEWAY						2	21227	7	U.	S.A.		
ا ج	11. MARITAL STATUS	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. A	RMED	13. V	NAS DEC	ENDENT C	F NISPAN	IC ORIGIN? (Specify Ye	a or No-	14. RACE	- American Indian,	
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES		1	YES	2 NO	Specify	n, Puerto Rican, etc.)		Speci		
			VIETNA									WHITE	
2	15. DECEDENT'S EDUC (Specify only highest grade	completed)	/	ECEDENT'S Give kind of v le. Do NOT us	vork done a	CUPATIO	ON st of workin	g	16b. KIND OF BU	SINESS/IND	USTRY		
COMPLETED	Elementary/Secondary (0-12) 12TH GRADE	College (1-4 or 5	')	ECHAN					COOLT	MC CV	ores.	rc.	
N N	17. FATHER'S NAME (First, Middle, Lest)		I K	IECHA	110				COOLI		SIEL	15	
	JOHN MARSHALL SHE	TETS SE					18. MOTE		ANCHE H.		מי		
BE	19a. INFORMANT'S NAME (Type/Print)	LID, DR.											
임	JOYCE SHEETS								ORE, MD	n, Stete, Zip 21227			
	20a, METNOD OF DISPOSITION		1	AND DATE		-		TITIC					
	1 A Buriel 2 Cremetion 3 Remo	val trom State	cemetery, cr	remetory or of	her plecel			ADIZ		CATION -		wn, State	
4 Donetion 5 Other (Specify)  MEADOWRIDGE MEMORIAL PARK 4/28 ELKR  21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY											RIDGE		
	· M Mark	1 Color	/		HU	BBAI	RD FU	NERA	L HOME, I	NC.			
_	23. PART I. Enter the diseases, or c	was	nan		41	07 1	VILKE	INS A	VENUE - B	ALTIM	ORE,	MD 21229	
COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION		DUE TO  DUE TO  DUE TO  B COntributing to  RIBUTE TO CA  HOSPITAL:  1 Inpetient 2  280. DATE OF (Month, Do building, Date of building, Date of building, Date of the best of the best of the best of the best of the best of the building, Date of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the best of the	(OR AS A CONSE  (OR AS A CONSE  deeth but npt  USE OF DE/ 26. PLA  ER/Outpatient: INJURY y, 'fear')  F INJURY — At hetc. (Specify)  my knowledge, d	COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUENCE OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF COUNTY OF	n the und  S N (Check o  OTHER 4 Nurse E OF URY M  treet, tacto	derlying  nly one) ing Home 28c. INJU WOI 1 Y  rry, office	UNC  5 GRe  JRY AT  RKY  ES 2 GRe  end place,	ERTAIN eldence (	PERFOI  1 YES 2  3 Other (Specify)  28d. DESCRIBE HOW I  28t. LOCATION (Street City or Town, State)  to the ceuse(e) end man	NJURY OCC	or Rural R	WERE AUTOPSY FINDINGS AWAIL ABLE PRIOR TO COMPLETION OF CAUSE OF OCATITY t YES 2 NO	
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	Che	ue	N	D		29c. LICE	NSE NUM	23a	29d. DATE	SIGNED	(Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	E OF DEATH ATE	M 27) (Tvna	Print)		الا	× 6	21	UPH	12	7(70	
	3455 Wille 31. DATE FILED (Month, Day, Year)	is Are	130		MD	2	122	9 -	- ASHOK	C	Hopi	RA	
	APR 2 8 1995 Jul	AT THE PERSON NAMED IN	A DADONAL.										



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

the funeral director, page 5 should be detached for use as the burial-transit rurs after death. Page 6 may be retained by the hospital or attending physician. signed by the attending physician and completely filled in by Health and Mental Hygiene prior to burial, cremation, or remo DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within After this certificate has been death with the State Dept. of DIRECTOR: After the hours after death TO THE FUNERAL D be filed within 72 ho IMPORTANT: If IN HOSPITAL TO THE

permit, Pages 1, 2, 3 should

notified at once,

must be

medical examiner

other traumatic event, the

6

item 23 shows any Injury,

0

28 is marked,

Hem

BY

COMPLETED

BE

2

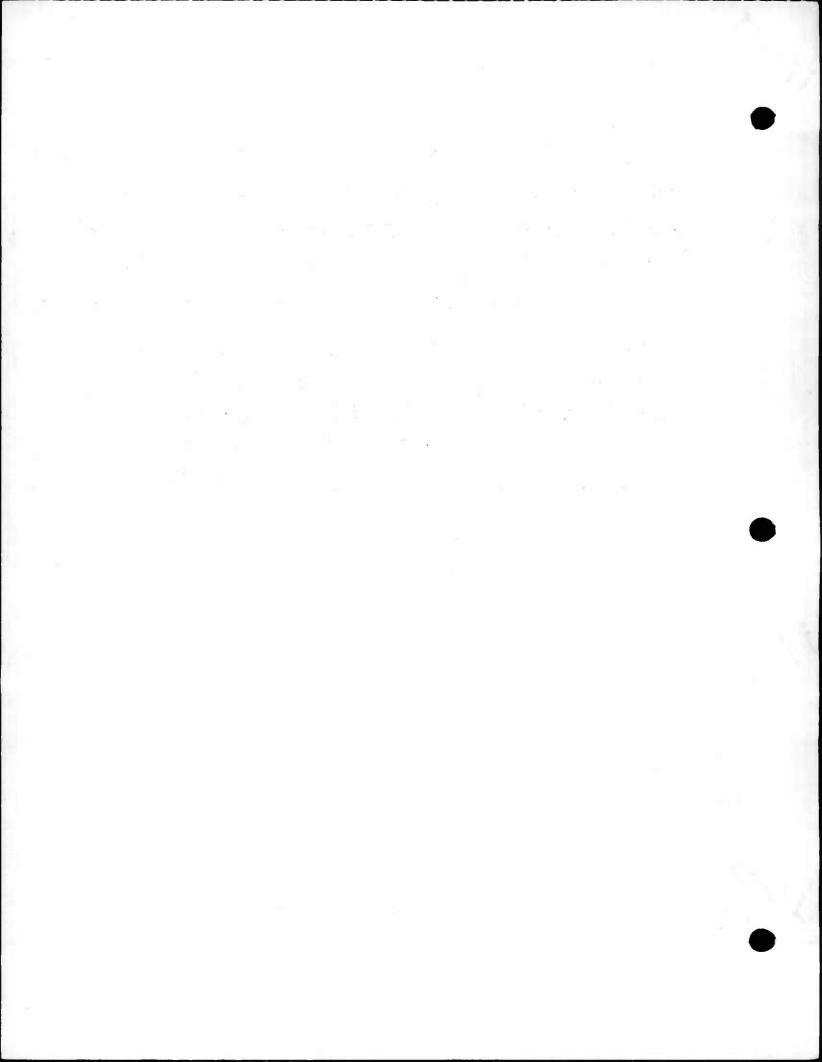
ITEMS: 27,29a STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE FOR STATE REGISTRAR 5. SEX 6. AGE (In vis IF UNDE R I YEAR 1 W M 2 | F 10h COUNTY 10c. CITY, TOWN OR LOCATION land WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 V YES 2 NO 2 Married WAR PRO 15. DECEDENT'S EOUCATION (Specify only highest grade complete ive kind of work done Do NOT use retired.) condary (0-12) ge (1-4 or 5 +) aintenanc

95 13098

1 -CERTIFICATE OF DEATH REG. NO. 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH Apri 10 P 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH IF UNDER 24 HRS. S. BIRTNPLACE (State or Foreigg 9b. CITY, TOWN OR LOCATION OF OEATH 9c. COUNTY/OF DEATH DIRECTOR MARP RESIDENC 10a. STATE 10d. INSIDE CITY LIMITS? 1 YES 2 NO more FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2 2 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Culsen, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black, White, atc. 1 Never Married B Specify: 3 Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION

The blad of work done during most of working COMPLETED 16b. KINO OF BUSINESS/INDUSTRY a 17, FATHER'S NAME (First, Middle, Last) BE 19b. MAILING ADORESS 2 lon 20s. METHOD OF DISPOSITION

1 1 Burlel 2 Cremetion 3 Removal from State PLACE AND DATE OF DISPOSITION (MA 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Josep nter the diseases, or complications that caused the death. Do not anter the mode of dying, auch ea cardiec or reapiratory arrest, Approximate shock, or has fallure. Liet only one cause on each line. intervei Between IMMEDIATE CAUSE (Final disease or condition_ DUE TO (OR IS A CONSEQUENCE OF) arrest resulting in deeth) wim 2. Carcinma CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONDEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST PART II. Other algorificent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS Medi-stiva AVAILABLE PRIOR TO bleed COMPLETION OF CAUSE OF DEATN? 1 YES 2 LNO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☑ 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATN (Check only one) **EXAMINER?** HOSPITAL: OTHER:
4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 YES 2 NO 1 Dipatient 2 ER/Outpatient 3 DOA tospi 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 26c. INJURY AT WORK? 28d. OESCRIBE NOW INJURY OCCURED 1XX Netural Pending 1 YES 2 NO 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) a Could not be determined 4 Nomicide 29a. CERTIFIER XXI CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the fime, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as attend. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month 9 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) JOTTSCH WY JOHNS HOPK 31. DATE FILEO (Month, 32 REGISTRAR'S SIGNATURE 8 1995 Julia attudes Roslate APR



rySICIAN: The law requires that the death certificate be executed within ours after death. Page 6 may be refained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely med in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	e medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within .	TO THE CONTROL OF After this certificate has been signed by the attending physician and completely limed in by the 1 be in writin ? I after death with the State Dept. or Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT THE MEDICAL SE IS MARKED, OF Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

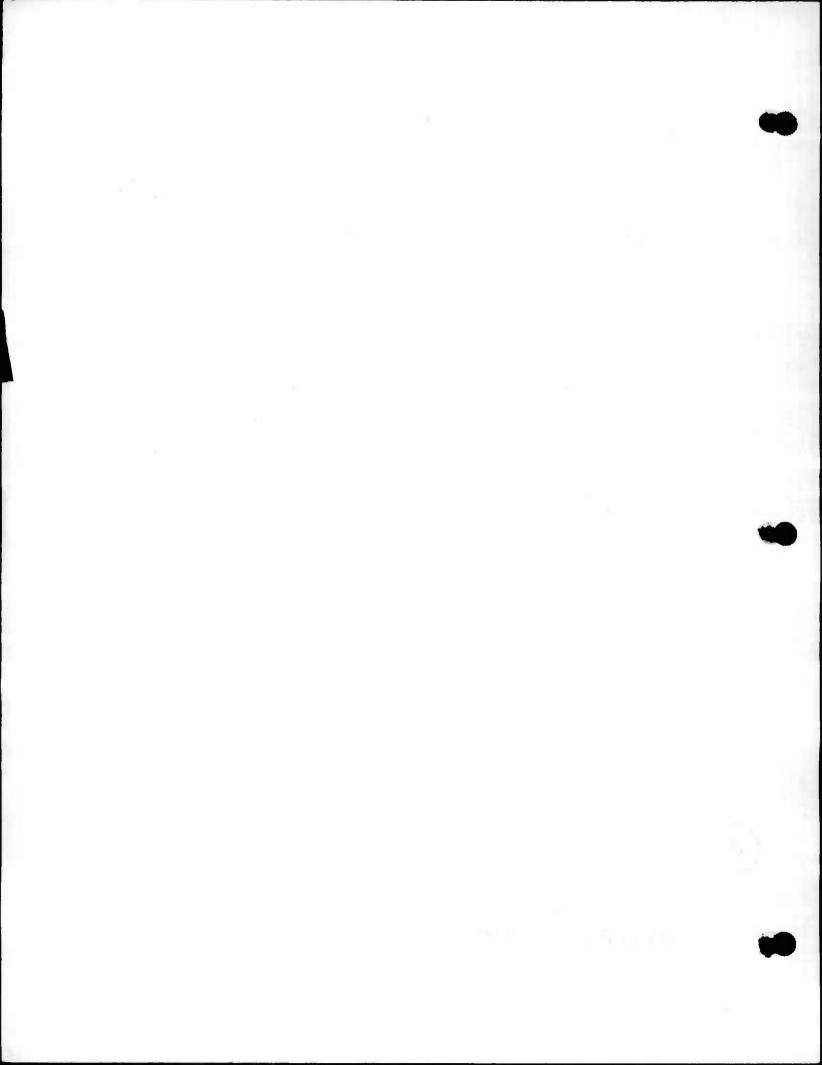
Manuel Levin,

APR 2 8 1995

M.D.,

	FOR	STATE OF MAS	RYLAND / DEPAR	TMENT OF	HEALTH AND N	MENTAL HYGIEN	E			
	1 - REGISTRAR		CERTIF	CATE O	F DEATH	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	Y YEA	3. TIME OF DEATH		
i	Norris				Smith	4 25				
		. SEX 6. A	79 YRS.	MONTHS DAY		7. DATE OF BIRTH (Month, Day, Year) 8 1 1		Printry) Tall 10		
	Sa. FACILITY NAME (If not institution, give street	and number)		9b. CITY, TOW	N OR LOCATION OF DE	ATH	9c. COUNTY	OF DEATH		
TOR	Pleasant Manor N	ursing Ce	sing Center Baltimore City					A		
DIRECTOR	Maryland 10b. county	I/A	10c. CIT	3alt	more			10d. INSIDE CITY LIMITS? 1 YES 2 NO		
FUNERAL	4615 Park	Heigh	ts Av	e.	21215	5	10g. CITIZEN	OF WHAT COUNTRY?		
5		2. WAS DECEDENT EV	VER IN U.S. ARMED	13. WAS I	DECENDENT OF HISPAN specify Cytien, Maxical	IIC ORIGIN? (Specify Year	or No- 14. I	RACE — American Indian, Black, Whita, etc.		
B	1 Never Merried 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR			(ES 2 NO Specify			Specify: Black		
8	15. DECEOENT'S EDUCAT (Specify only highest grade con		16a. DECEDENT'S (Give kind of	vork done during	ATION most of working	16b. KIND OF BU	SINESS/INDUST	RY		
PLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	L OF	o retired.)	r	Long	Shar	reman		
COMPL	17. FATHER'S NAME (First, Middle-Last)	S	naith		18. MOTHER'S NAI	ME (First, Middle, Manual				
8	19a JNFORMANTIS NAME (Type/Prigt)	7	19b. MAILING	ADDRESS (Stre	et and Number or Rural F	Route, Number, City or Tow	n, State Zip/Code	Θ)		
유	Martha Gay	es	135%	2 Hor	nesteo	d St. E	Balto	, Md. 21218		
	20a. METHOD OF DISPOSITION  1  Burial 2 Cremation 3 Ramova  4 Donation 5 Other (Specify)	I from Stata	other place)	TION (Name of	cemetery, crematory or	20c, LO	CATION - DITY	or Town, Stata Whe Md		
	21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE A		JOS	AND ADDRESS OF PA	GILITY	inera	I Home		
	seph	d. T	USS	22	25 W.N	orth Ave	2, Ba	Ho. Md. 21216		
	23. PART I Enter the diseases, or con shock, or least failure. Lis			not antar tha	mode of dying, suc	h as cardiac or reep	Iratory arrest,	Approximete interval Batween		
	IMMEDIATE CAUSE (Finel disease or condition	UR	TOP ASUS					2 Lago		
	resulting in death) a	DUE TO (OR	AS A CONSEQUENCE O	F):	0 - 11.	10.0	0	1 2/1		
NO	Sequentielly liet conditions, if any, leeding to immediate cause. Enter UNDERLYING  DUE TO (OR AS A CONSEQUENCE OF):  A aflekie Suadher & Chroic Urmay Mass infectes 24 als poly to (OR AS A CONSEQUENCE OF):  Sequentielly liet conditions, if any, leeding to immediate cause. Enter UNDERLYING  DUE TO (OR AS A CONSEQUENCE OF):  A aflekie Suadher & Chroic Urmay Mass infectes 24 also so the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of									
ERTIFICATION	if any, leeding to immediata cause. Enter UNDERLYING	Reus	mlord as	throbs 6	rever & Re	nel Facle	us	6 4000		
TIF	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR	AS A CONSEQUENCE O	P: Jula	e beede	n		1 Wek		
CER	d	~ //		700		V				
AL S	PART II. Other significant conditions of	ontributing to da	ath but not resulting	In the underi	ying cause given in	PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE		
EDICA						1 YES :	NO	OF DEATH?		
≥								1 - 123 2 - 110		
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				. PLACE OF DEATH (Ch	eck only one)				
YSIC	1 - YES 2 0 NO 1	IOSPITAL:	VOutpatient 3 DOA	OTHER: 4 Nursing I	Home 5 - Residence	8 Other (Specify)				
г рну	27. MANNER OF DEATH  1) Natural 5 Pending	28a. DATE OF INJ (Month, Day, 1	(URY 28b. Tilk	JURY	INJURY AT WORK?	28d. DEŞCRIBE HOW	INJURY OCCURE	ED		
ED BY	2 Accident Investigation 3 Suicide 8 Could not be determined 4 Homicide determined Investigation 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  28a. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)						and Number of R	tural Route Number,		
(E	29a. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the hest of my	knowledge death occur	ad at the time	dete and place and due	to the cause(s) and ma	nner on stated			
18	one)	_						use(a) and manner as stated.		
00)	296. SIGNATURE AND TITLE OF CERTIFIER	1 9	1 m	7 7	29c. LICENSE NUI	MBER	29d. DATE SIG	NED (Month, Day, Year)		
TO B	Man	uur /	evir /	P	D 05	621	17/	26/95		
-	30. NAME AND ADDRESS OF PERSON WHO C		OF DEATH (ITEM 27) (Type		Da 14 ima	ND 21	215			

6101 Park Heights Ave., Baltimore, MD



death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 after hours DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burda-transit permit. Pages 1, and the State Deat. of Health and Mental Hydiene prior to burdal, cremation, or removal.	
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HOSPTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing shours after death. Page 6 may be retained by the hospital or attending physician.	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi within 72 hours after death with the State Deot, of Health and Mental Hydiene prior to burlal, cremation, or removal	I lem 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
R ATTE	RECTOR urs afte	Im 28
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 5. TIME OF DEATH 2057, 1995YEAR LEE DIANE SHAFFNER APRIL 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. a. BIRTHPLACE (State or Foreign Oct. 21, 219-52-8955 1 🗆 M 2 ី F 45 YRS. 1949 Maryland 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL DIRECTOR N/A RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland N/A Baltimore 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? 3110 McElderry ST. 21205 U. S. A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Noif yes, specify Cuben, Maxican, Puerto Ricen, etc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2.
IF YES, GIVE WAR OR DATES 1 Never Married 2 X Merried BY Specify: 3 Widowed 4 Divorced White 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) Elementary/Secondery (0-12) College (1-4 or 5+) 12th Grade Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surneme) Herman A. Ulbig Iona Marge Valentine 띪 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Robert L. Shaffner (Husband) 3110 McElderry Street, Baltimore, Md. 21205 20e, METHOD OF DISPOSITION
1 M Suriet 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Gardens of Faith 4/28 Baltimore, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY UM Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Md. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, ahock, or heart feilure. List only one ceuse on sech line intarval Between **IMMEDIATE CAUSE (Fine)** Onset and Death disease or condition resulting in death) MULTI SYSTEM ORGIAN FAILURE 2 weeks DUE TO (OR AS A CONSEQUENCE OF): DUERVHELMING SEPSIS CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immadiate cause. Enter UNDERLYING DIVERTICULITIS AND CHOLELYSTITIS CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algoriticant conditions contributing to death but not resulting in the Underlying cause given in Pert i. MEDICAL 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE DF OEATH? 1 TYES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: EXAMINER? OTHER: 1 TES 2 NO patient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Yeer) 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation Ĕ 3 Sulcide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) 28 Is COMPLETED 8 Could not be 4 Homicide determined 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee atated. = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end manner ee stated.

296. SIGNATURE AND TITLE OF CEN 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MD

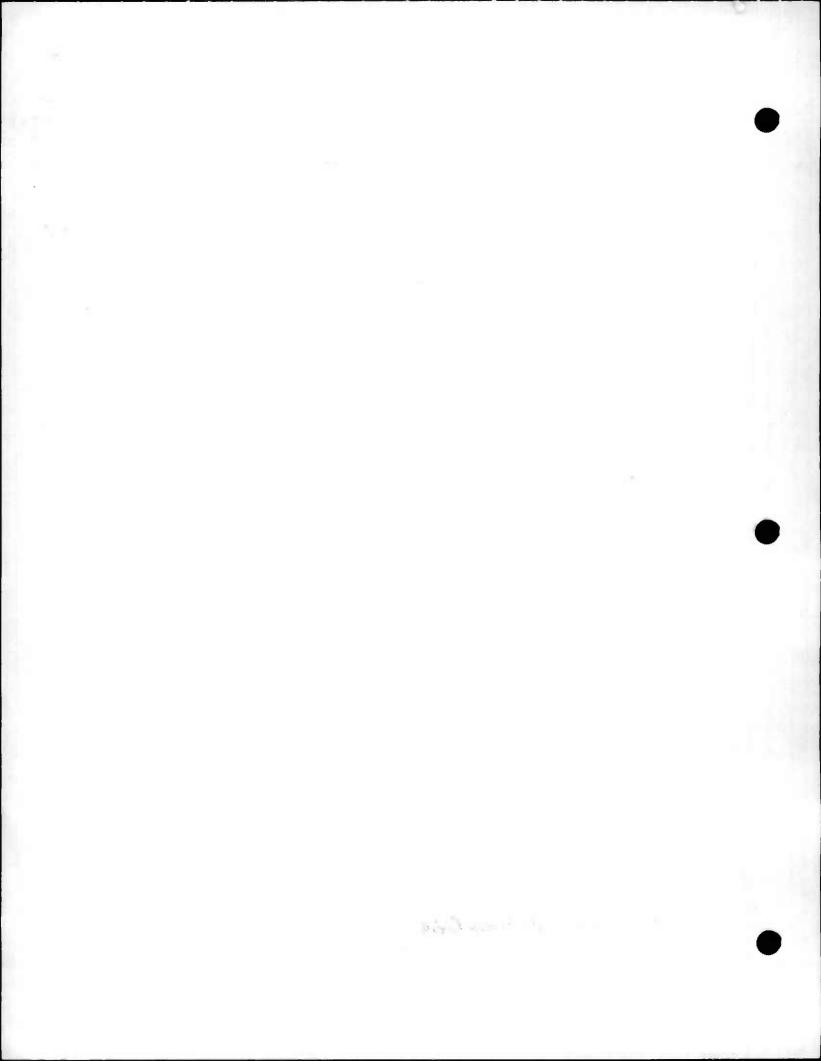
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BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146.

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this are used. Tage o may be retained by the nospital of attending physician.	his certificate has been signed by the attending physician and completely med in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Debt, or Health and Mental Hymlene prior to burial cremation, or removal.	e medical examiner must be notified at once.
TO THE HUSPITAL OR ALLENDING PHISTORING, THE TAY TO UNITED THE USE UNDER THE BACCURE OF EMECUTION WITHING	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fined in by the has such within 20 hours after death with the State Dent, of Health and Mental Hydiene prior to build, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLANI	) / DEPAR						HYGIEN REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last ERMAB.	)	r.					2. DATE OF	DEATH D	26	YEAR 9C	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 219-18-9739	5. SEX 6. AGE (In yrs	t. lest birthday) YRS.	IF UNDER	UNDER 1 YEAR IF UNDER 24 HRS. ITHIS DAYS HOURS MIN.			7. DATE OF BIRTH 8. BIRTH			8. BIRTHP	O. Md.
FOR	90. FACILITY NAME (If not institution, give Northwest Hospi RESIDENCE OF DECEDENT		100		allst		ATH		9c. COU	B	altimore	
FUNERAL DIRECTOR						r, TOWN OR LOCATION  Reisterstown  10d. INSIGE CITY LIMITS?  1 □ YES 2 🗓 NO						
IERAL	100. STREET AND NUMBER 206 Estate Road	đ			101	211				10g. CITI	ZEN OF W	HAT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	X NO		yes, sp		ı, Mexican	C ORIGIN? (		s or No	Black, Specifi	- American Indian, White, etc. Thite
COMPLETED	15. DECEDENT'S EC (Specify only highest gra- Elamentary/Secondery (0-12) High School	DUCATION de completed)  College (1-4 or 5+)	L DECEDENTS (Give kind of life. Do NOT a HOUSE	work done d	CUPATIO luring mo	OM at of working	g	18b. Ki		SINESS/IND		•.
BE CON	17. FATHER'S NAME (First, Middle, Lest) Elzie McKins	ey Higgs					Mav	AE (First, Mid LGCVLE)	t Neu	man		
5	192. INFORMANT'S NAME (Type/Print) Walter A. Ski		206	Estat	te R	d, Re	eiste	oute Number, 275±01				
	20b. METHODO OF DISPOSITION 1 [X] Burlal 2 [ Cremetion 3 [ Ramoval from Stata   4 [ Donellon 5 [ Other (Specify) ]   20b. PLACE OF DISPOSITION (Name of cametary, cremetary or other place)   20c. LOCATION — City or Town, Stata other place)   20c. DISPOSITION (Name of cametary, cremetary or other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LOCATION — City or Town, Stata other place)   20c. LO											
	21. SIGNATURE OF FUNERAL SERVICE	38C-		22. 1	NAME A	ND ADDRES	S OF FAC	HLITY	1182	4 Rei	ster	stown Rd. Md. 21136
	23. PART i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition)  Approximate interval Between Onset and Death											
7	DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	Sequentielly list conditions, If any, leading to immediate ceuse. Enter UNDERLYING CALISE (Disease or Injury											
ERTIF	that initieted events resulting in deeth) LAST	d.	NSEGUENCE (	# p								
PHYSICIAN: MEDICAL (	1 U YES 2 N NO COMPLETION OF CALL									AVAILABLE PRIOR TO COMPLETION OF CAUSE		
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO	HOSPITAL:	- 2 T DOA	OTHER	₹:			6 Other (	0		•	
	27. MANNER OF OEATH  1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. 17		28c. IN.	URY AT ORK?		28d. OESCI		INJURY OC	CURED	
TED BY	2 Accident 3 Suicide 8 Could not be determined	28a, PLACE OF INJURY	At home, farm.	, street, fact	ory, offic	•			ION (Street Town, State		r or Rural A	oute Number,
COMPLETED	(Crisick Orlly	YSICIAN: To the best of my knowledg										and manner se stated.
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER  296. LICENSE NUMBER  296. LICENSE NUMBER  296. DATE SIGNED (Month, Day, plant)  10 10 10 10 10 10 10 10 10 10 10 10 10 1										Wonth, Day, Mean)	
<b>⊢</b> I	I 30 NAME AND ADDRESS OF DEDSON I	WHO COMPLETED CAUSE OF DEATH	ATEM 270 /5-	an Delegt						_		

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF OEATH (Check only one)  OTHER: OTHER: OTHER: OTHER: OTHER: OTHER: OTHER: OTHER: OTHER: OTHER: OTHER: OTHER: OTHER: OTHER: OTHER: OTHER: OTHER: OTHER: OTHER: OTHER: OTHER: OTHER: OTHER:								
1 VES 2 NO  27. MANNER OF OEATH  1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?  1 YES 2 NO	6 Unther (Specify)  28d. DESCRIBE HOW INJURY OCCURED						
3 Suicide 8 Could not be determined	28e. PLACE OF INJUSTY — At hor building, etc. (Specify)	me, farm, street, fe	ctory, office	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)						

29b. SIGN TURE AND TITLE OF CERTIFIER	mo	29c LICENSE NUMBER D 43750	29d, DATE SIGNED Worth, Day, (feat)

_			
1.0	HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typa, Print)  TETYRY K. OSET NOTETHER)	- HOSPITAL	BATTIMORE

31. DATE APR 2 8 1995

1/1/1/10

Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description		FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPARTA	MENT OF I	HEALTH AND	MENTA	L HYGIENI REG. NO.	E			
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22. NAME AND ADDRESS OF FACELY  TOWSON FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACELY  TRUCK TOWSON, Md. 21204  23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Beave Check, or heart fishers. List only one cause on seek line.  IMMEDIATE CAUSE (Final diseases or condition)  IMMEDIATE CAUSE (Final diseases or condition)  IS sequentisity list conditions, if any, leading to immediate cause. Enter UNDERTY, IND.  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENC		20a. METHOD OF DISPOSITION	2	0b. PLACE AND DATE OF D	ISPOSITION (Na						, Stata	
22. NART NE OF FUNCHAL SERVICE LICENSEE  22. NART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Chapter of Part II. Enter the diseases, or complications that cause on asch line.  23. PART I. Enter the diseases, or complications that cause on asch line.  13. IMMEDIATE CAUSE (Final diseases) or house on asch line.  24. IMMEDIATE CAUSE (Final diseases or condition and on the cause on asch line.  25. METASTATIC LIVER CARCINOMA  26. DUE TO (OR AS A CONSEQUENCE OF):  27. DUE TO (OR AS A CONSEQUENCE OF):  28. CAUSE (Disease or injury)  29. The cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause o		4 Donation 5 Other (Specify)	Н		rice Co			5 Tow	son, N	ıd.		
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23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line.  IMMEDIATE CAUSE (Final diseases or conditions or sulting in death)  DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, at any, leading to immediate cause. Enter INIDERITYING CAUSE; (Diseases or injury thin initiated events cause the first of the cause of injury thin initiated events cause the first of the cause of injury thin initiated events cause. Enter INIDERITYING CAUSE; (Diseases or injury thin initiated events cause)  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (												
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PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.  PART III. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.  PART III. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.  PART III. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.  PART III. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.  PART III. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.  PART III. Other algnificant conditions  PART III. Other algnificant conditions  PART III. Other algnificant conditions  PART III. Other algnificant conditions  PART III. Other algnificant conditions  PART III. Other algnificant conditions  PART III. Other algnificant conditions  PART III. Other algnificant conditions  PART III. Other algnificant conditions  PART III. Other algnificant conditions  PART III. Other algnificant conditions  PART III. Other algnificant conditions  PART III. Other algnificant conditions  PART III. Other algnificant conditions  PART III. Other algnificant conditions  PART III. Other algnificant conditions  PART III. Other algnificant conditions  PART III. Other algnificant conditions  PART III. Other algnificant conditions  PART III. Other algnificant conditions  PART III. Other algnificant conditions  PART III. Other algnificant  PART III. Other algnificant  PART III. Other algnificant  PART III. Other algnificant  PART III. Other algnificant  PART III. Other algnificant  PART III. Other algnificant  PART III. Other algnificant  PART III. Other algnificant  PART III. Other algnificant  PART III. Other algnificant  PART III. Other algnificant  PART III. Other algnificant  PART III. Other algnificant  PART III. Other algnificant  PART III. Other algnificant  PART III. Other a	ATION	If sny, leading to immediate cause. Enter UNDERLYING										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    24a. WAS AN AUTOPSY PERFORMED?   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   1   YES 2   NO   NO   YES 2   NO   NO   YES 2   NO   NO   YES 2   NO   NO   YES 2   NO   YES 3   YES 3   YES 3   YES 3   YES 4   YES 3   YES 4   YES 3   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4   YES 4	ERTIFIC	that initiated events	A CONSEQUENCE OF):	OF):								
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DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN  26. PLACE OF DEATH (Check only one)  27. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 DO  28. DATE OF INJURY (Month, Day, Wasr)  28. DATE OF INJURY (Month, Day, Wasr)  28. DATE OF INJURY (Month, Day, Wasr)  28. DATE OF INJURY (Month, Day, Wasr)  28. DATE OF INJURY (Month, Day, Wasr)  28. DATE OF INJURY (Month, Day, Wasr)  28. DATE OF INJURY (Month, Day, Wasr)  28. DATE OF INJURY (Month, Day, Wasr)  28. DATE OF INJURY At home, farm, street, factory, office  28. DATE OF INJURY AT WORK? 1 YES 2 NO  28. DESCRIBE HOW INJURY OCCURED  28. DESCRIBE HOW INJURY OCCURED  28. LOCATION (Street and Number or Rural Route Number, City or Rown, State)  28. CERTIFIER (Check only one)  29. SIGNATURE AND TITLE OF CERTIFIER  29. SIGNATURE AND TITLE OF CERTIFIER  29. SIGNATURE AND TITLE OF CERTIFIER  29. LICENSE NUMBER  29. DATE SIGNED (Month, Day, Wasr)  29. STORM DADRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  NATIVIDAD D. DELEON, M.D., ST JOSEPH MEDICAL CENTER, 7620 YORK RD., TOWSON, MD. 21 20  31. DATE FILED (Month, Day, Wasr)  32. REGISTRAR'S SIGNATURE	20								1	CC	OMPLETION OF CAUSE	Ė
25. WAS CASE REFERRED TO MEDICAL  26. PLACE OF DEATH (Check only one)  27. MANNER OF DEATH  28. PLACE OF DEATH (Check only one)  28. PLACE OF DEATH (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. CERTIFIER (Check only one)  29. MEDICAL EXAMINER: On the beat of my knowledge, daeth occurred at the time, data and place, and dua to the cause(e) and manner as stated.  29. CERTIFIER (Check only one)  29. MEDICAL EXAMINER: On the beat of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(e) and manner as stated.  29. CERTIFIER (Check only one)  29. MEDICAL EXAMINER: On the beat of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(e) and manner as stated.  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 95.08  29. DI 9		DID TODA CCO LIST COL	A TENDE TO CALLES							1	TYES 2 NO	
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Description of the best of my knowledge, death occurred at the time, data and piaca, and dua to the cause(s) and menner as stated.    29b. Signature and Title Of Certifier	훉	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME O	F 28c, INJ	URY AT			JURY OCCUR	NED		_
28a. PLACE OF INJURY — At home, farm, street, factory, office  29a. CERTIFIER (Check only one)  29b. SIGNATURE AND TITLE OF CERTIFIER  30b. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  29c. LICENSE NUMBER  29c. LICENSE NUMBER  29d. LOCATION (Street and Number or Rural Route Number, City or Rown, State)  29d. DATE SIGNED (Month, Day, Year)  29d. DATE SIGNED (Month, Day, Year)  29d. DATE SIGNED (Month, Day, Year)  29d. DATE SIGNED (Month, Day, Year)  21d. DATE FILED (Month, Day, Year)  21d. DATE FILED (Month, Day, Year)  21d. DATE FILED (Month, Day, Year)  21d. DATE FILED (Month, Day, Year)  21d. DATE FILED (Month, Day, Year)  21d. DATE FILED (Month, Day, Year)  21d. DATE FILED (Month, Day, Year)  21d. DATE FILED (Month, Day, Year)  21d. DATE FILED (Month, Day, Year)  21d. DATE FILED (Month, Day, Year)  21d. DATE FILED (Month, Day, Year)  21d. DATE FILED (Month, Day, Year)  21d. DATE FILED (Month, Day, Year)  21d. DATE FILED (Month, Day, Year)  21d. DATE FILED (Month, Day, Year)  21d. DATE FILED (Month, Day, Year)  22d. DATE SIGNED (Month, Day, Year)		2 Accident Investigation	on		M 1 1	rES 2 NO						
296. SIGNATURE AND TITLE OF CERTIFIER  1 Strided S. de Leon, M. J.,  29c. LICENSE NUMBER  29c. LICENSE NUMBER  29d. DATE SIGNED (Month, Day, Year)  4 Gyril 26, 1995  29d. DATE SIGNED (Month, Day, Year)  4 Gyril 26, 1995  29c. LICENSE NUMBER  29d. DATE SIGNED (Month, Day, Year)  4 Gyril 26, 1995  31. DATE FILED (Month, Day, Year)  32. REGISTRAR'S SIGNATURE	<u>a</u>	O O OOGIG HOL	building, etc. (50	RY — At home, farm, stree secify)	t, factory, office		26f. LOC City	ATION (Street an or Town, State)	nd Number or	Rural Rout	e Number,	
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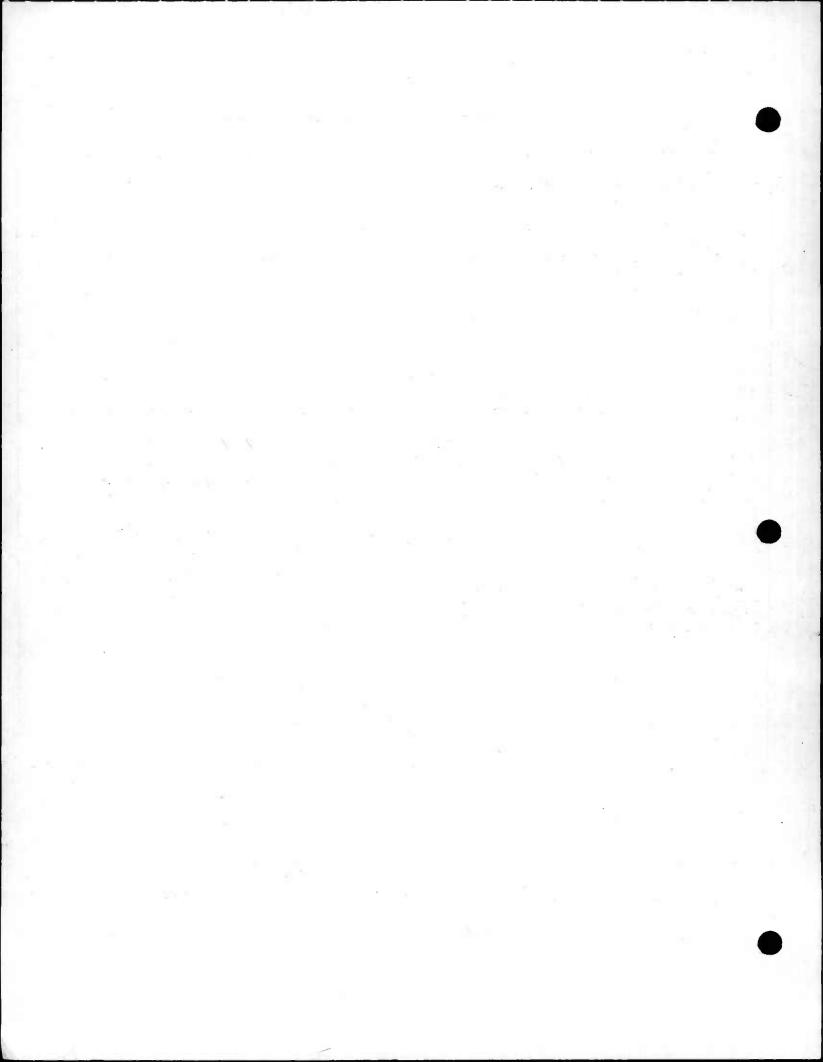
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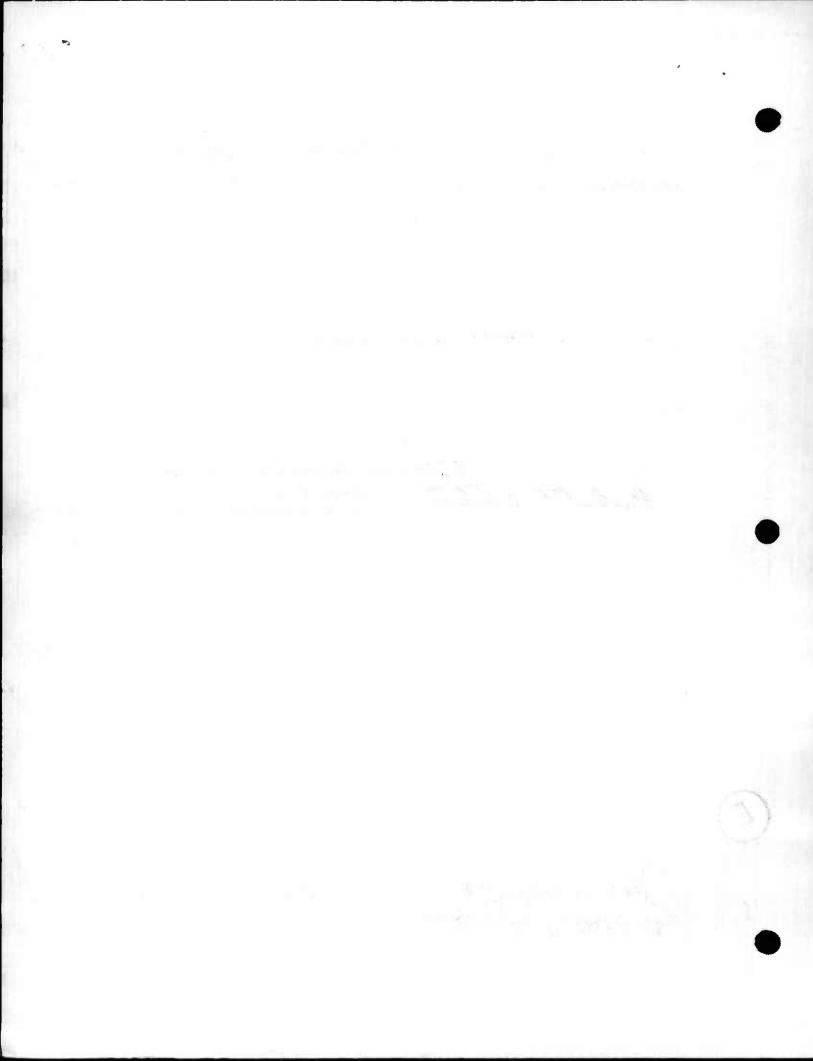
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		1 - FOR STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTM CERTIFICA			MENTAL HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Lest) CHARLES	WILLIAM			JND, SR.	2. DATE OF DEATH	2. DATE OF DEATH MONTH APRIL 25, 1995 YEAR 2:		
pin		4. SOCIAL SECURITY NUMBER 216-03-8034	1 <b>欠M</b> 2□F 84	YRS. MON		IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) SEPT. 12,	8. BIRT Coun 1910 MA	HPLACE (State or Foreign itry) RYLAND	
21215-0020 al or attending physician. for use as the burial-transit permit. Pages 1, 2, 3 should	TOR	90. FACILITY NAME (If not institution, give sti ST. JOSEPHS HOSPI RESIDENCE OF DECEDENT			96. CITY, TOWN OR LOCATION OF DEATH TOWSON			9c. COUNTY OF DEATH BALTIMORE		
	DIRECTOR	MARYLAND BA	LTIMORE		OC. CITY, TOWN OR LOCATION TOWSON			10d, INSIDE LIMITS' 1 YES		
	UNERAL	800 SOUTHERLY ROA				21204	10g. CITIZEN OF WHAT COUNTRY? USA			
	BY F	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES  13. WAS DECENDENT OF HI If yes, specify Cuben, M. 1 ☐ YES 2 ☐ NO S.		cify Cuben, Mexica	n, Puerto Rican, etc.)	Blec	CE — American Indian, ck, White, etc. CHY. WHITE		
	LETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	DECEDENT'S USUA (Give kind of work of life. Do NOT use retir	ione during mos		166. KIND OF BUS	SINESS/INDUSTRY		
YLAND 2 by the hospital be detached to at once.	COMPL	12 17. FATHER'S NAME (First, Middle, Lest)	4	ACCOUNT	'ANT		ME (First, Middle, Malden		OUDE	
MARYL retained by 5 should be	TO BE	CHARLES  19a. INFORMANT'S NAME (Type/Print)  CHARLES W. SIEGMU					Foute Number, City or Town 108 OCEAN	n, State, Zip Code)	D. 21842	
MORE, age 6 may be director, page		20e. METHOD OF DISPOSITION 1	20b. PLA	CEAND DATE OF DIS , crematory or other pi TOP SERV	POSITION (Nat	ne of		CATION — City or T	lown, State	
death. P death. P funeral		21. SIGNATURE OF SUNERIAL SERVICEARCE	JOHN. E. I	OOLAN	RUCK		FUNERAL HOMAD TOWSON,		04	
d within 24 hours after of myletely filled in by the 1, cremation, or removal.		23. ART Enter the diseases, or construction of the second shock, or heart feiture. Limited sease or condition resulting in death)	omplications that caused the list only one cause on each such that the list only one cause on each one of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list of the list	(mon	nter the mod	fishing, such	The Lung	ratory errest,	Approximate interval Between Onset and Death	
of P.O. BOX 086.  death certificate be execute i attending physician and co ental Hygiene prior to buria iry, or other traumatic	CERTIFICATION	Sequentielly flat conditions, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OF AS A COM	Mizely	اع	Lukes	Demer	tra	5425	
requires that the sen signed by the of Health and Michael thought the shows any injury	MEDICAL	PART II. Other significant conditions			,	3.111.0124.74.214.114.11	PERFOR	MED?	MERIC AUTOPSY FRIDINGS MAKLABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY 1 YES 2 NO	
L law law 23 bept	PHYSICIAN:			LACE OF BEATTER	HER:	UNCERTAIN				
Reference PHY C	ву рну	27. MANNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year)	IBD. TIME OF	284. INJU WOR	TA YIII	6 Other (Specify) 28d. DESCRIBE HOW IF	NURY OCCURED		
OR ATTENDING I DIRECTOR: After hours after death	<b>□</b>	3 Suicide 6 Could not be departished	28e. PLACE OF BUJURY — A building, etc. (Specify)	t home, farm, street,	factory, office		28f. LOCATION (Street a City or Town, State)	nd Number or Rural	Route Mumber	
TAL OR YAL DIRI	COMPLET		IAN: To the best of my knowledge : On the beste of examination end						a) end menner ae stated.	
TO THE HOSPI TO THE FUNEF be filed within	TO BE (	29b. SIGNATURE AND TITLE OF CENTIFIER	Can 1	- hover		29c, LICENSE NUM D 29	769	29d. DATE SIGNED	(Month, Day, Year)	
10			ALBUERNE 516 r	n. rollin	g Rd.	BALTIMO	RE, MD. 21	228		
		PR 2 8 1995	PERSONAL SEGNATUR	t						

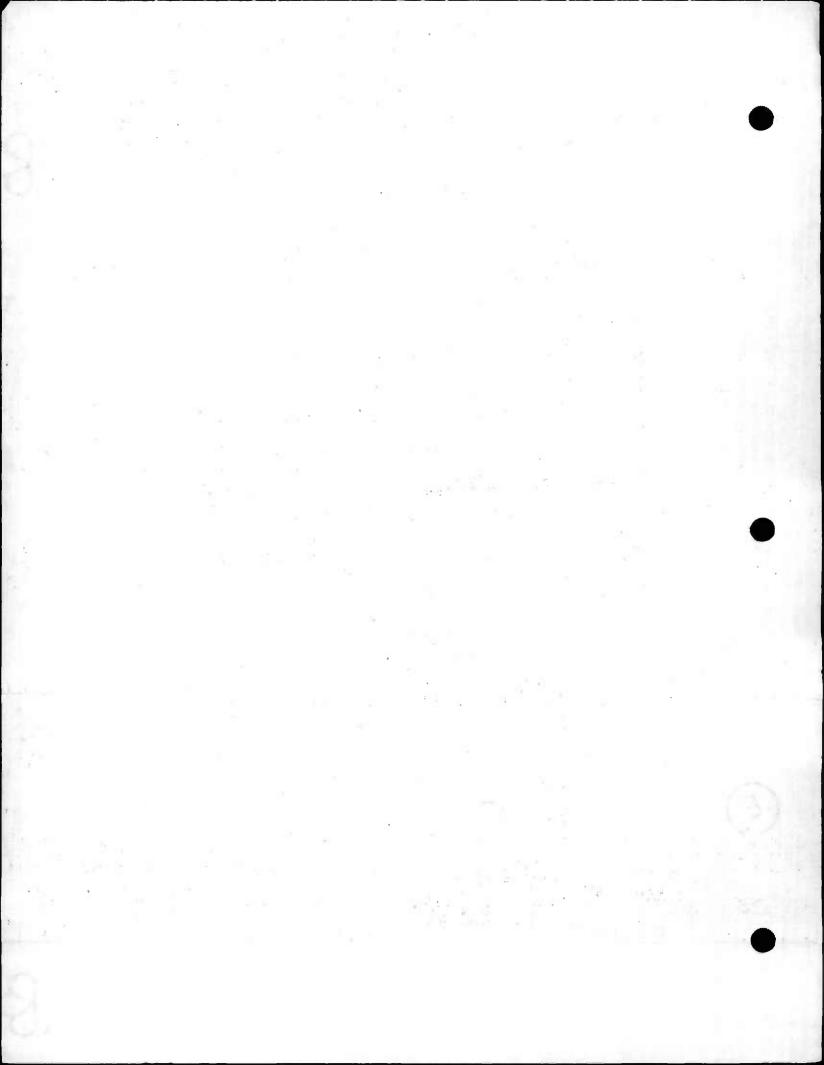


	TO THE HOSTINE OF AT MOING PHYSICIAN: The law requires that the death cen	nding	Hyg	IMPORTANT User 28 is marked, or item 23 shows any injury, or of
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	that	Da Da	h an	any
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	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last) DONALD ECKN	IAN		Smi	th	2. DATE OF DEATH		YEAR _	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 196-10-6830	XX M 2 □ F 74	4 YRS.	IF UNDER 1 YEAR HONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Yea OCT 17,	r)	8. BIRTNP Country)	LACE (State or Foreign	
TOR	9e. FACILITY NAME (If not institution, give street and number)  9b. CITY, TOWN OR LOCATION OF DEATN  9c. COUNTY OF DEATN  PENINSULA REGIONAL MEDICAL CENTER SALISBURY  WICOMIC									
DIRECTOR	10a. STATE 10b. COUNTY Delaware Sussex			10c. CITY, TOWN OR LOCATION Dagsboro					10d. thiside city Limits?	
	10e. STREET AND NUMBER	Da	101.		10g. CITIZ		1 TYES 2XX NO			
FUNERAL	P.O. Box 61	(near Dagsbot		1 10 1110 050			USA			
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? VIX YES IF YES, GIVE WAT OR DA World War	2 NO ATES	If yes, spe	ENDENT OF NISPAN rolfy Guban, Maxican 2 ⁴⁴ NO Specify:	ic Officiar; (Specify i, Puarto Rican, etc.	Yea or No-	NO— 14. RACE — American Indian, Black, White, atc. Specify: White		
ETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION o completed) Callege (1-4 or 5 +)	18a. DECEDENT'S U: (Give kind of wo life. Do NOT use	rk done during mos	N st of working	18b. KIND OF	BUSINESS/INDU	ISTRY	WILLE	
COMPLET	12	College (1-4 or 5+)	Buildin	g Contra	actor	Const	ruction	n		
	17. FATNER'S NAME (First, Middle, Last)	b				AE (First, Middle, Mei				
B	Joseph W. Smit  19a. INFORMANT'S NAME (Type/Print)	n	19b. MAILING A	OORESS (Street ar	Bertha  Number or Rural R		Eckman	Code		
5	Miriam Eubanks Sm	ith_								
	Miriam Eubanks Smith P.O. Box 61, Dagsboro, Delaware 19939  20a, METHOD OF DISPOSITION  AB Buriat 2 Cremation 3 Removal from State 1 Dagsboro Redmens Cemetery 4/24 Dagsboro, Delaware 19939  20b. PLACEAND DATE 20c. LOCATION — City or Town, State 2 Commetory, Crematory or other place)  Dagsboro Redmens Cemetery 4/24 Dagsboro, Delaware									
g.	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  Watson Funeral Home, Inc.									
	Kithand	· Waki	on _	211 Wa	shington	St., Mi	illsbor	o, D	E_19966	
	23. PART i. Enter the diseases, or ahock, or heart fellure.  iMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Metasta	etic lole			as cerdiac or re	espiratory arre	at,	Approximats Interval Between Onset and Death	
CERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):									
MEDICAL	PERFORMEO? 1 □ YES 2 ※ NO 0						WERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?			
N.	DID TOBACCO USE CONT				UNCERTAIN					
SICI/	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 ☐ YES 2 ☒ NO	HOSPITAL:		OTHER:						
PHYSICIAN:	27. MANNER OF DEATN	10€ Inpetient 2 ☐ ER/Outp 28a, DATE OF INJURY	28b. TIME	OF 28c. INJU	5 Rasidenca (	28d. OEŞCRIBE NO	W INJURY OCCU	JREO		
ВУР	1 🔀 Netural 5 🗌 Pending 2 🔲 Accident Investigation	(Month, Day, Year)	INJUF	M 1 🗆 Y	K?					
	3 Suicide 8 Could not be 4 Homicide determined	3 Suicide 8 Could not be 28a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify)								
COMPLETED		ICIAN: To the best of my knowl								
БСС	296. SIGNATURE AND TITLE OF CERTIFIE				29c, LICENSE NUMI				Jonth, Day, Year)	
TO BE	HW a. Route	entrey MD.	ATN (ITEM 27) (Type, P	hráme)	1585%	7	D 4/	20/	95	
	JOHN ROUTEN APR	, MD. 26		ON ST	SALK	BUM, MI	2/50	5/		
	APR 2. 8 1995	ill 3" at terrationer for	of pily			1				



	MONTH DAY YEAR										3. TIME OF OEATH		
	4. SOCIAL SECURITY NU.	JMBER		6. AGE (In yrs. Ia 79	st birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER 24 HP	N. (Mo.	E OF BIRTH  1th, Day, Year)  -25-19	915		IPLACE (State or Fore
<u>۳</u>	9e. FACILITY NAME (If not institution, give etreet end number)  9b. CITY, TOWN OR LOCATION OF DEATH  9c. COUNTY OF DEATH												
DIRECTOR	RESIDENCE OF D	10b. COUNT	Greater Washington Rockville Montgomer							10d. INSIDE CITY			
DIR	Ohio	Cuya	hoga			eveland Height		hts	S			LIMITS?	
3AL	10e. STREET AND NUMB	ER				10f. ZIP CODE				10g. CITI2			WHAT COUNTRY?
FUNER	3880 Mayf	ield F		oad #108		1	44121						S.A.
BY	1 Never Married 2 3 Wildowed 4 1 0		FORCES? 1 [ IF YES, GIVE WA	YES 2	NO NO		WAS DECE If yee, spe I \( YES	cify Cuben, Me	SPANIC ORIG exican, Puert pecify:	IN? (Specify Ye Ricen, etc.)	e or No	14. RACI Blac Spec	E — American Indiar k, White, etc. #y: White
ETED	15. D (Specify	DECEDENT'S EDU- only highest grade	CATION completed)	(0	ECEDENT'S	work done		N at of working	10	b. KIND OF BU	SINESS/INC	DUSTRY	***************************************
PLE	Elementary/Secondary	y (0-12)	College (1-4 or 5+)		Do NOT u		0						C
COMPL	-12- 17. FATHER'S NAME (First	t, Middle, Last)							Towish Family Servic NAME (First, Middle, Meiden Surneme)				
BE C	Nathan Le							Gite	1 Me	tz			
5	Norman Sc												7a. 220
	Norman Solomon 500 N. Roosevelt Blvd. #214 Falls C												
medical examiner must	20b. PLACE AND DATE OF DISPOSITION   DATE   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. Document   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commence   Commenc												
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  IVES-PEARSON FUNERAL HOMES												
	FALLS CHURCH, VA. 22046												
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, about, or have failure. List only one ceuse on each line.  MMMEDIATE CAUSE (Finel disease or condition												
	resulting in death)												
Z	Sequentially list conditions												
	If any, leading to immediate cause. Enter UNDERLYING												
ATI	If any, leading to imi			CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):									
IFICATI	If any, leading to im- cause. Enter UNDER CAUSE (Disease or i that initiated events	ILYING Injury	c. DUE TO (C	OR AS A CONSE	OUENCE O	F):							
ERTIFICATI	If any, leading to im- cause. Enter UNDER CAUSE (Disease or i	ILYING Injury	c.  DUE TO (C	OR AS A CONSE	OUENCE O	F):							
DICAL CERTIFICATION	If any, leading to im- cause. Enter UNDER CAUSE (Disease or i that initiated events	AST	d,	- <u></u> -			nderlying	ceuse giver	ı In Pert i.	24a. WAS AN PERFO	RMED?	24t	AVAILABLE PRIOR 1
	if any, leading to imicause. Enter UNDER CAUSE (Disease or i that initiated events resulting in deeth) L  PART II. Other eignif	AST Condition	d.	lesth but not	resulting	in the ur					RMED?	246	AVAILABLE PRIOR T COMPLETION OF CA OF DEATH?
AN: MEDICAL	if any, leading to impossible to the cause. Enter UNDER CAUSE (Disease or in that initiated events resulting in deeth) Leading to the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the c	AST  CO USE (	d.	lesth but not	resulting	in the ur	т үі	ES 🔲 N	40 🗆	PERFO	RMED?	24t	AVAILABLE PRIOR T COMPLETION OF CA OF DEATH?
SICIAN: MEDICAL	if any, leading to imicause. Enter UNDER CAUSE (Disease or i that initiated events resulting in deeth) L  PART II. Other eignif	AST  CO USE (	d.	TO CAU	resulting	DEA1	TH YI 26, PL	ES	NO [	PERFO	RMED?	241	AVAILABLE PRIOR T COMPLETION OF CA OF DEATH?
SICIAN: MEDICAL	if any, leading to imicause. Enter UNDER CAUSE (Disease or i that initiated events resulting in death) L  PART II. Other eignif  DID TOBAC  25. WAS CASE REFERREE EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH	AST  CO USE ( D TO MEDICAL	contributing to d	TO CAU	SE OF	DEA1	26. PL	ES	O (Check only	PERFO	RMED?		AVAILABLE PRIOR 1 COMPLETION OF CO OF DEATH?
AN: MEDICAL	If any, leading to imicause. Enter UNDER CAUSE (Disease or i that initiated events resulting in deeth) L  PART II. Other eignif  DID TOBAC  25. WAS CASE REFERREI EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Netural 5 2 Accident	AST  CO USE (	CONTRIBUTE  HOSPITAL: 1   Inpatient 2    28e. DATE OF II (Month, Day	TO CAU  ER/Outpetlent: NJURY , 'Year')	SE OF	DEAT  OTHER  4*2 Nur  BE OF  JURY	26, PL 26, PL 3: sing Home 28c, INJI WOI 1 — Y	ES NACE OF DEATH  5 G Resided  JRY AT  RK?  2 NO	NO D	PERFO  1  YES :  none)  ver (Specify)  ESCRIBE HOW	RMED?  2 NO  INJURY OC	CURED	AMALABLE PRIOR I COMPLETION OF COOP DEATH?  1 YES 2 N
ED BY PHYSICIAN: MEDICAL	If any, leading to imicause. Enter UNDER CAUSE (Disease or i that initiated events resulting in deeth) L  PART II. Other eigniff  DID TOBAC  25. WAS CASE REFERRER EXAMINER?  1  YES 2 NO  27. MANNER OF DEATH  1 Netural 5 2  Accident	AST  CO USE CO D TO MEDICAL  Pending	CONTRIBUTE  HOSPITAL: 1   Inpatient 2    28e. DATE OF II (Month, Da)	TO CAU  ER/Outpetlent: NJURY , 'Year')	SE OF	DEAT  OTHER  4*2 Nur  BE OF  JURY	26, PL 26, PL 3: sing Home 28c, INJI WOI 1 — Y	ES NACE OF DEATH  5 G Resided  JRY AT  RK?  2 NO	NO D (Check only) nce 8 Dt 28d. D	PERFO  1 YES:	RMED?  2 NO  INJURY OC	CURED	1 YES 2 NI
ED BY PHYSICIAN: MEDICAL	If any, leading to imicause. Enter UNDER CAUSE (Disease or i that initiated events resulting in deeth) L  PART II. Other eignif  DID TOBAC  25. WAS CASE REFERREE EXAMINER?  1  YES 2 NO  27. MANNER OF DEATH  1 Netural 5 2  Accident 3  Suicide 8 4  Homicide	AST  CO USE ( D TO MEDICAL  Pending Investigation  Could not be determined	DONTRIBUTE  HOSPITAL: 1   Inpatient 2    28e. DATE OF II (Month, Day)  28e. PLACE OF building, e	TO CAU  ER/Outpetient : NJURY , /veir) INJURY — At htc. (Specify)	SE OF  3 □ DOA  28b. TIN IN,	DEAT  OTHER 4 Nur HE OF JURY M street, fect	26. PL. R: sing Home 28c. INJ WOI 1 Y	ES NACE OF DEATH	Ci	PERFO  1 VES:  1 VES:  CATION (Street y or Town, State	RMED?  2 NO  INJURY OC.	CURED or Rural	AMALABLE PRIOR T COMPLETION OF CA OF DEATH? 1 YES 2 N
ED BY PHYSICIAN: MEDICAL	If airy, leading to imicause. Enter UNDER CAUSE (Disease or i that initiated events resulting in deeth) L  PART II. Other eigniff  DID TOBAC  25. WAS CASE REFERREI EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5 2 Accident 3 Suicide 8 4 Homicide	ILYING Injury  AST  CO USE  D TO MEDICAL  Pending Investigation  Could not be determined	CONTRIBUTE  HOSPITAL: 1   Inpatient 2    28e. DATE OF II (Month, Da)	TO CAU  ER/Outpetient :  NJURY , / Year)  INJURY — At htc. (Specify)	SE OF  3 DOA  28b. TIM IN.  ome, ferm,	DEAT  OTHEL 4 Nur HE OF JURY M  street, fect	TH YI  26. PL.  R: sing Home  28c. INJI  WOI  1  Y  tory, office	ACE OF DEATH  5 GREENder  TRK7  ES 2 NO	NO I (Check only) nce 8 Ot 28d. D	PERFO  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES :  1 VES	RMED?  2 NO  INJURY OC  and Number	CUREO or Rural	AMALABLE PRIORI TO COMPLETION OF CLOP DEATH*  1 YES 2 N
BE COMPLETED BY PHYSICIAN: MEDICAL	If airy, leading to imicause. Enter UNDER CAUSE (Disease or i that initiated events resulting in deeth) L  PART II. Other eigniff  DID TOBAC  25. WAS CASE REFERREI EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5 2 Accident 3 Suicide 8 4 Homicide	ILYING injury  AST     Could not be determined	CONTRIBUTE  HOSPITAL: 1   Inpatient 2   28e. DATE OF II (Month, Day) 28e. PLACE OF building, e	TO CAU  ER/Outpetient :  NJURY (, Year)  INJURY — At htc. (Specify)  ny knowledge, diministion end/or	SE OF  3 DOA  28b, TIM IN, orne, ferm,	DEAT  OTHEL 4 Nur HE OF JURY M  street, fector, in my of	26. PL. R: sing Home 28c. INJU WOO 1  Year	ACE OF DEATH  5 GResided  7 Review  5 No.	NO I (Check only) nce 8 Ot 28d. D 28f. LC Cl due to the c	PERFO  1 VES:  Ner (Specify)  ESCRIBE HOW  CATION (Street y or Town, State  ause(s) and me te end place, e	INJURY OC  and Number  onner ee atar	CURED or Rural .	AMALABLE PRIOR I COMPLETION OF COMPLETION OF COP DEATH?  1 YES 2 N
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TO BE COMPLETED BY FUNERAL DIRECTOR

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ZF hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR	STATE OF MARYLA		ENT OF HEALTH AND	MENTAL HYGIEN		
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH
FRANCES 1	MARIE	TUCK	FR	MONTH D. 4 - 25	9	EAR 2 0 ms M
4. SOCIAL SECURITY NUMBER 5.	. SEX 6. AGE (A		NOER 1 YEAR   IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign
217-46-4209 1	□ M 2 XF	77 YRS. MONT	THE DAYS HOURS MIN.	(Month, Day, Year) 5-18-15	- 1	Country)
9a. FACILITY NAME (If not institution, give street	and number)	9b.	CITY, TOWN OR LOCATION OF D		9c. COUNTY	OF DEATH
GoldEN DAKS	NURSING +	tomE 1	AUREL, ma			NE GEORGE
RESIDENCE OF DECEDENT	10 010311000 1	101112	FIUNCE , MIT	2	LEL	NUZ GEOKGE
10a. STATE 10b. COUNTY		10c. CITY, TO	WN OR LOCATION			10d. INSIDE CITY LIMITS?
	ARUNDE	Loth	LIAN.			1 YES 2 NO
10s. STREET AND NUMBER			10f. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
337 MARIB	ORD RD		2071	1	115	SA.
	P. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DECENDENT OF HISPA	NIC ORIGIN? (Specify Yas	or No.— 14.	RACE — American Indian,
1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DA		If yes, specify Cuben, Maxicon  1 YES 2 NO Specific			Black, White, etc. Specify:
3   Widowed 4   Divolced						WHITE
15. DECEDENT'S EDUCAT (Specify only highest grade con	ION npleted)	16a. DECEDENT'S USUA (Give kind of work of	AL OCCUPATION one during most of working ed.)	16b, KIND OF BU	SINESS/INDUS	TRY
Elementary/Secondary (0-12)	College (1-4 or 5+)				_	
/2		Homem	AKER	Own 1	Home	
17. FATHER'S NAME (First, Middle, Last)				AME (First, Middle, Maiden		
William E.	TUCKER		JUSEC	KINE (	Bertt	1+h
19e. INFORMANT'S NAME (Type/Print)		19b. MAILING ADD	RESS (Street and Number or Rural	Route Number, City or Tow	n, State, Zip Co	ole)
Gerald Tucker			yard Road,			20711
20a. METHOD OF DISPOSITION	20b.	PLACE AND DATE OF DIS	POSITION (Name of	DATE 20c 10	CATION City	or Town State
1 St Buriel 2 Cremetion 3 Removal 4 Donation 5 Other (Specify)	from State Ceme	etery, crematory or other pi	. M. Cemete	777 4/00	Toth-	or lown, state
21. SIGNATURE OF PUNERAL SERVICE LICENS	SEE A. IA	21011 0	22. NAME AND ADDRESS OF FA	T 4 / KO	LOUI.	lan, MD
21/	// ///		Hardesty Fu		ne. P.	Α.
Dalrick I	Candel L		12 Ridgely			
23. PART I. Enter the diseases or com	plications that caused	the death. Do not a	ntar the mode of dying, suc	ch as cardiec or respi	ratory arrest	Approximate
anock, or near sellure. List	only one cause on ac	ch line.				Intarval Batwean
IMMEDIATE CAUSE (Final disease or condition	METAL	20	25 6 6			Onset and Death
resulting in death) a	776773/	1777C/76	TENO (PACSA	0/2/7		1704545
Sequentielly list conditions, b		CONSEQUENCE OF:	1 many	28020	G	
if any, leading to immediate ceuse. Enter UNDERLYING	DOE TO (OR AS A	CONSEQUENCE OF):				
CAUSE (Disease or Injury C	DUE TO COD AS A	CONSEQUENCE OF:				
that initiated avents resulting in death) LAST	DUE TO (OH AS A	CONSEQUENCE OF):				
d						
PART II. Other significant conditions of	ontributing to death by	it not resulting in the	underiving cause given in	Part I. 24a, WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS
ANEMIA				PERFOR		AVAILABLE PRIOR TO
				1 YES 2	NO	OF DEATH?
_ ASCVO						1 TES 2 NO
DID TOBACCO USE CONTRIB	UTE TO CAUSE OF	DEATH YES	□ NO □ UNCERTAL	NB		
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	6. PLACE OF DEATH (CH				
	☐ Inpatient 2 ☐ ER/Outpa		HER: Nursing Home 5 - Residence	6 Other (Specify)		
27. MANNER OF DEATH	26e, DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJURY AT	28d. DESCRIBE HOW I	NJURY OCCUR	ED
1 Natural 5 Pending	(morkii, Day, rear)	INJURY	WORK7 1 YES 2 NO			
2 Accident Investigation 3 Suicide 8 Could not be	280. PLACE OF INJURY	- At home, farm, street,	factory, office	281. LOCATION (Street a	and Number or F	Sural Bouts Number
4 Homicide determined	building, atc. (Special	(y)		City or Town, State)		na in the training of
29a. CERTIFIER						
(Check only			he time, data and pieca, and due			
2 MEDICAL EXAMINER: C	in the beele of examination	end/or investigation, in	my opinion, death occured at the	time, date and place, an	d due lo the co	suse(a) end manner as stated.
296. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NU	MBER	29d. DATE SI	GNED (Month, Day, Year)
Sin	7		0254	122	D 4	25/95
30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, Print)				1./-
il mai	cod, m					
31. DATE FILED (Month, Day, Year)		r feet/		<u> </u>		
APR 2 8 1995	62. TEIST AR'S STA	ariah				

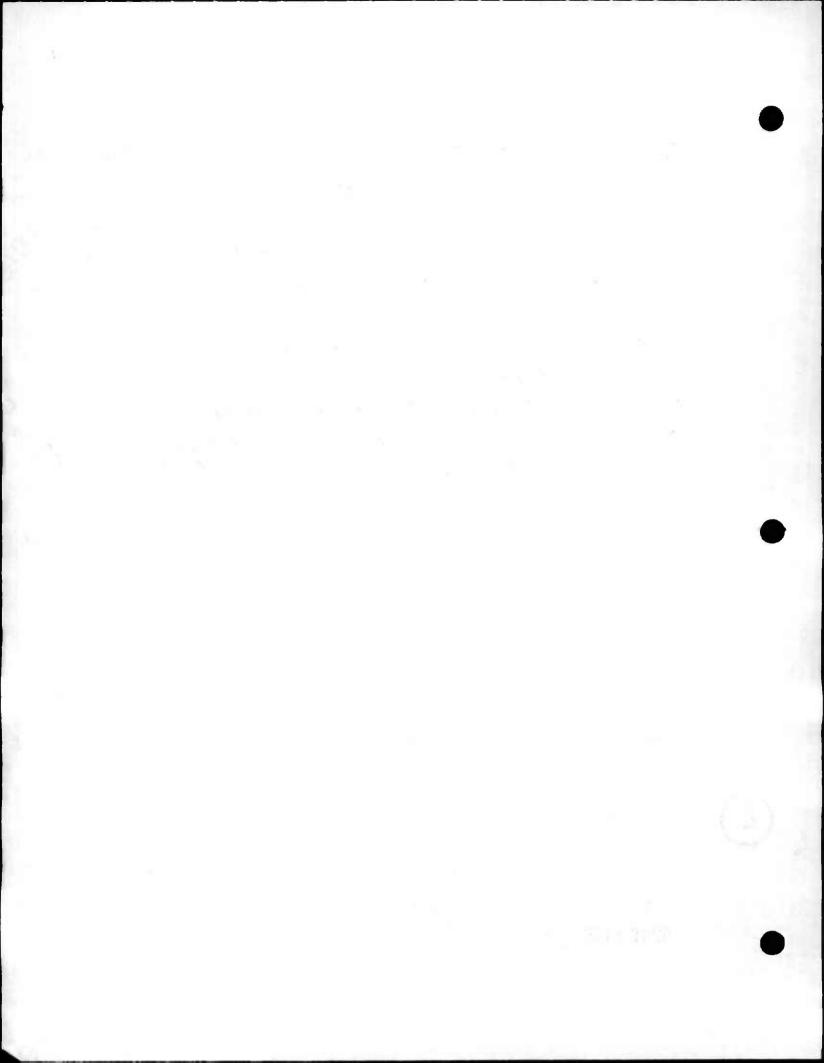
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STATES OF ALMECORDS, P.O. BOX 68760	FUDING PHYCICIAN: The law requires that the death certificate he executed within
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31. DATE FILED (Month, Day, Ybar) APR 2 8 1995

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 25 1995 RANDOLPH APRIL THOMAS 10:03 A 7. DATE OF BIRTH (Month, Day, Year 6. AGE (In yrs. last birthday IF UNDER 24 HRS. IF UNDER 1 YEAR 1 M M 2 - F DAYS Pages 1, 2, 3 should 9a. FACILITY NAME (# 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEA DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY permit. 1 YES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? completely filled in by the funeral director, page 5 should be detached for use as the bunia-transit rial, cremation, or removal. 6 after death. Page 6 may be retained by the hospital or attending physician. 17 MARITAL STATUS 13. WAS DECEMDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: 12. MAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 14. RACE 1 Never Married 2 Married IF YES, GIVE WAR OR DATES B 3 Widowed 4 Divorced ETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INOUSTRY College (1-4 or 5+) COMPL notified at once. 17. FATHER'S NAME (First, Middle, Last) BE 2 must be 206. PLACE AND DATE OF DISPOSITION IN the medical examiner 21. SIGNATURE QE 22. NAME AND ADDRESS OF 21 PARTA Frilef the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory erreet, **Approximate** shock, or heart failure. Liet only one cause on each line. interval Between IMMEDIATE CAUSE (Finel Onset and Death disease or condition MY OCEN SEL EN interctio or other traumatic event, resulting in death) i mned side and com burial, CERTIFICATION Sequentially list conditions, prior to DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events the attending p resulting in death) LAST PART II. Other eignificant conditione contributing to deeth but not reculting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS signed by t Health and AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 23 shows any Vascula 1 TES 2 NO 1 TES ZONO t. of t DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) EXAMINER? YES 2 NO certificate HOSPITAL: OTHER: 1 Inpatient 2 ER/Outpatient 4 Nursing Nome 5 Residence 6 Other (Specify) 0 the 27. MANNER OF DEATN 26e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF marked. 28d. DESCRIBE HOW INJURY OCCURED with this 1 YES 2 NO BY death Accident Investigat 26e. PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 90 3 Suicide COMPLETED 6 Could not be 4 Nomicide 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my kn dge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On nvestigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOS TO THE BOOK MANAGEMENT OF THE PROPERTY. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) April 25, 1995 1022 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 900 Avenue

DNMH-18 Rev 1/89



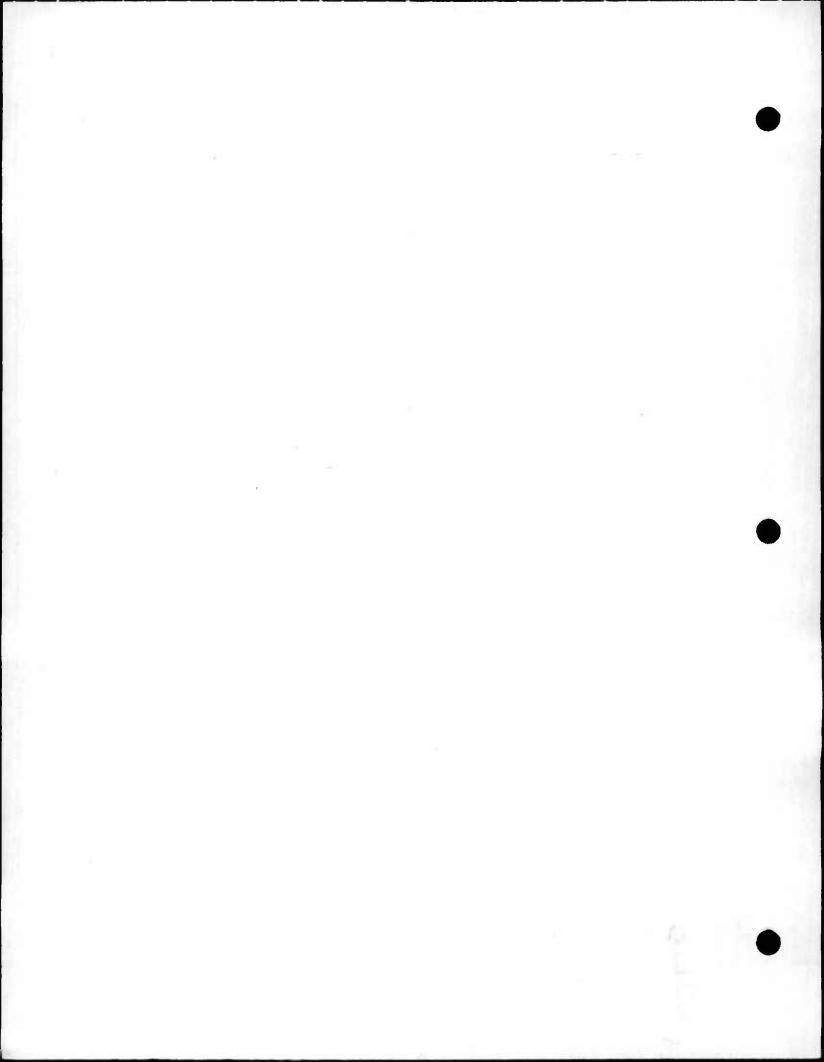
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPART	MENT OF H	EALTH AND	MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	TH 3. TIME OF DEATH				
	u	Villiam R	oy	Via		April 25	1995 YEAR	8:10 AM M			
				IF UNDER 1 YEAR	IF UNDER 24 HRS.	2 DATE OF BIRTH	A BUDG	MRI ACE /State or Engine			
	216→10→2775 1  9e. FACILITY NAME (If not institution, give street	M 2 F 87	YRS.	ONTHS DAYS	HOURS MIN.	Month, Day, Yoar) Dec. 12, 1		rginia			
5	98. FACILITY NAME (It not institution, give street and number)  96. CITY, TOWN OR LOCATION OF DEATH  2711 Edison Highway  86. COUNTY OF DEATH  87. COUNTY OF DEATH  N/A										
5	RESIDENCE OF DECEDENT										
DIRECTOR	Maryland 106. COUNTY	10c. CITY, TOWN OR LOCATION  Baltimore (			ore Citu	City 10d. INSIE					
AL	10a. STREET AND NUMBER		101	ZIP CODE	order order	10g. CITIZEN OF WHAT COUNTRY?					
FUNERAL	2711 Edison Highw	2121			213	13 United S					
E	11. MARITAL STATUS 12 1 Never Married 2 Married	P. WAS DECEDENT EVER IN 1 FORCES? 1 TYPES	U.S. ARMED 2 NO	13, WAS DEC	ENDENT OF HISPAI	NIC ORIGIN? (Specify Years, Puerto Rican, etc.)	Ble	E — American Indien, ck, Whits, sic.			
BY	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DAT					white				
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade con	ION	16s. DECEDENT'S US	SUAL OCCUPATION	N .	16b. KIND OF BU	ISINESS/INDUSTRY	WIDOCC			
E	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life. Do NOT use i	WILCO.							
MP	7 Years		Blac	ck Smith	i	Steel	Industr	y			
8	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maider	Surname)				
8	Robert Via		1			Shiflett					
2	Mrs. Betty Via					Ploute Number, City or Tovaltimore,		01012			
	20s. METHOD OF DISPOSITION	20b. f	I ACE AND DATE OF	DISPOSITION /No	ma of	DATE 200 16	CATION CO 7	Constant			
	1 1 Burlai 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	from State Germet	tery crematory or othe	Faith (	Cem. 4/2	8/95 Ro	Asvillo	MD			
ļ	21. SIGNATURE OF FUNERAL SERVICE LICENS	BEE		22. NAME AN	O ADDRESS OF FA	cility eral Home	. / 10 /	01. 7			
	•			7922 0	Vise Ave	erak Home • Dundalk	os vunda . MD 21	cr, inc. 222			
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate										
	IMMEDIATE CAUSE (Finel										
	resulting in deeth)  a. metastatic bladdel CA										
_	DUE TO (OR AS A CONSEQUENCE OF):										
0	Sequentially list conditions, first any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										
S	cause. Entar UNDERLYING										
Ē	CAUSE (Disease or Injury that initiated eventa	DUE TO (OR AS A C	CONSEQUENCE OF):								
CERTIFICATION	resulting in deeth) LAST										
	PART II. Other significent conditions contributing to death but not reculting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS										
§ ∥	end-stape	renal face	we.			PERFO	RMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE			
	Muu	2(0 dik Di	potic	sun a	Imme	1 □ YES :	100	OF DEATH?			
ž	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF	DEATH YES	□ NO □	UNCERTAIL	V (DX		1 123 2 Q (NO			
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	8. PLACE OF DEATH								
XS.	1 YES THO.	☐ Inpatient 2 ☐ ER/Output		THER:	Residence	6 Other (Specify)					
F	27. MANNER OF DEATH  Netural 5 Pending	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME (		JRY AT	26d. DESCRIBE HOW	INJURY OCCURED				
à l	2 Accident investigation	20- DI 105 OF WHITE			ES 2 NO						
COMPLETED	3 Suicide 8 Could not be determined	28a. PLACE OF INJURY building, etc. (Specify	- At home, farm, stre	et, lectory, office		261. LOCATION (Street City or Town, State,	and Number or Rural	Route Number,			
9	29e. CERTIFIER ON CERTIFYING PHYSICIAN	N. To the best of an investiga			Viet Calv						
ğ	(Check only one) 2 MEDICAL EXAMINER: 0	N: To the best of my knowled						a) and manner or stated			
	29b. SIGNATURE AND/TIPLE OF CERTIFIER	. 0									
B	1/ ndone	Valle	MO		29c. LICENSE NUR	781	▶ 4 to	(Month, Day, Year)			
2	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEAT	H (ITEM 27) (Type, Pr	int)	- D - C	1 1	1/4	170			
	VICTORIA	A VANI	K MD	341	00 pre	lmo han	salt,	MD 2/2/3			
	APR 2 8 1995	32. REGISTRAR'S SIGNAT	URE								



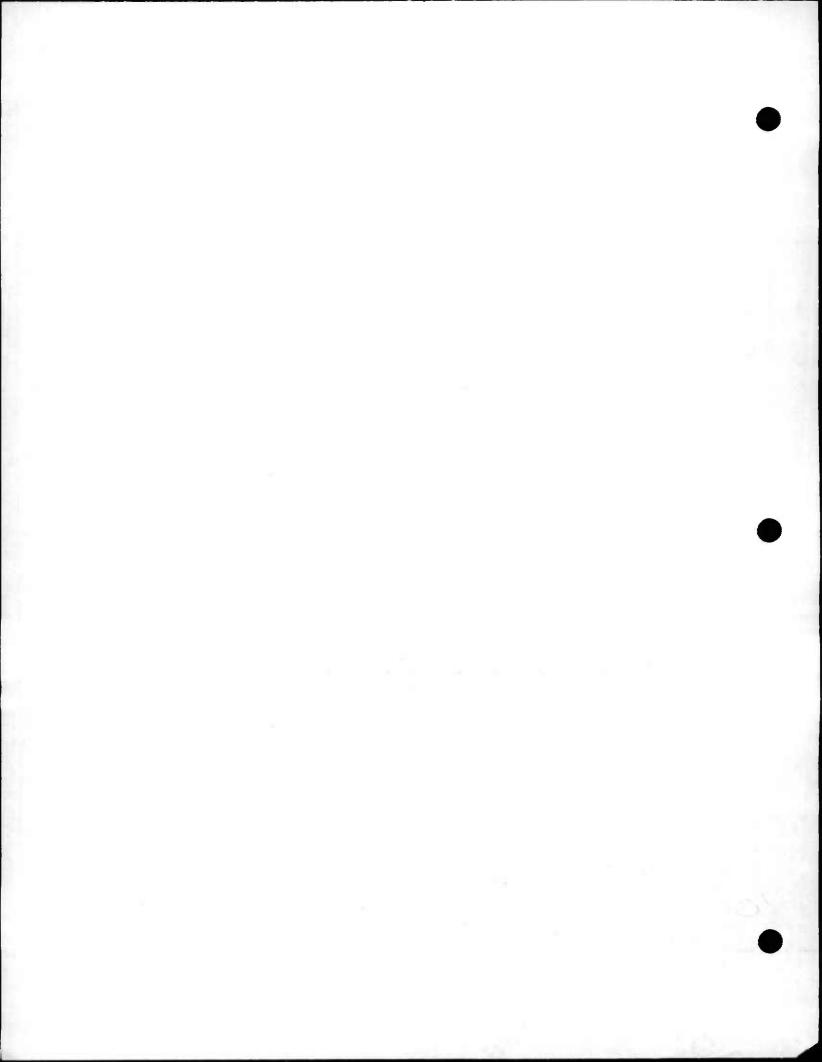
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1 - FOR STATE REGISTRAR

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	1	Cornelia	Miko	V	eshin	ski				ADri	DAY	1995	7:55 a
		4. SOCIAL SECURITY NUMB		5. SEX		yrs. last birthday		YEAR DAYS	IF UNDER 24 HRS.	7. DATE OF (Month, D	BIRTH	8. BIF	TTHPLACE (State or Foreign untry)
Pin		189-03-030		1 M 2 K F	83	YRS.	111111111111111111111111111111111111111		HOURS MIN.	Octol	er 6,	1912	Pennsylvania
3 should	Œ	9a. FACILITY NAME (If not in Manor Care		,			1	WSC	OR LOCATION OF D	DEATH		Balti	
1, 2,	2	RESIDENCE OF DEC	EDENT										
permit. Pages 1, 2,	DIRECTOR	MD Baltimore Baltimore							TION				10d. INSIDE CITY LIMITS? 1 YES 2 NO
**	FUNERAL	3123 Hiss		101. ZIP CODE 21234					109. CITIZEN OF WHAT COUNTRY? U.S.A				
hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-transit or removal. <b>medical examiner must be notified at once.</b>	BY	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divo-	Charles and the	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES	2 X NO	l II	yes, sp	ENDENT OF HISPA ecify Cuban, Maxic 2 NO Speci	an, Puarto Rica	pecify Yea or n, etc.)	81	ACE — American Indian, ack, White, atc. ecity: White
al or attend for use as	ETED.		EOENT'S EDUC highest grade			(Give kind of	work done du	CUPATIO	ON ost of working			IESS/INDUSTRY	
the hospital detached once.	COMPL	12				Buye	r			N,	'A		
d by the	BE CO	17. FATHER'S NAME (First, Mi	Miko				18. MOTHER'S NAME (First, Middle, Maiden Surname)  Veronica Dworchak					ık	
y be retained age 5 should be notified	2	19m. Informant's Name (Type/Print) Mrs. Josephine Dorak					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3123 Hiss Avenue Baltimore, Maryland 21234						
le 6 may be rector, page must be		20a. METHOD OF DISPOSITI 1X Burtal 2 Crematio 4 Donation 5 Other	n 3 🗆 Ramo (Specify)		20b. P	LACE AND DATE	eofdisposit SheNati	vit	y Cemet	ery5/1	P1 ymo	outh Pe	Town, Stata nnsylvania
is after death. Page 6 m in by the funeral director, removal.		21. SIGNATURE OF FUNERAL	0	J. K	la		22. N	O E	Belair R	oad Ba	e Dip	pel Fu 2120	neral Home 1
ne death certificate be executed within a hou the attending physician and completely filled. Mental Hygiene prior to burial, cremation, or Ijury, or other traumatic event, the m	CERTIFICATION	immediate condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  Onest and Dad OCARD (A INFACTION OF STAND OCARD) (A INFACTION OF STAND OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OCARD OC									COSTAN		
law requires that the same signed by seen signed by lept. of Health and 23 shows any In	: MEDICAL	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.  Plant II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.  Plant II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.  Plant II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.  Plant II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contribution contribution contribution contribution contribution contribution contribution contribution contribution contribution contribution contribution contribution contribution contribution contribution contribution contribution contribution contribution contribution contribution contribution contribution contribution											
PHYSICIAN: The la this certificate has with the State Deg rked, or Item 23	YSICIAN	EXAMINER? 1 YES 2 NO		HOSPITAL:	ER/Outpeti		OTHER:		e 5 Residence	8 Other (Sc	ecity)		
OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate his nours after death with the State Diem 28 is marked, or item	ву рну		Pending nvestigation	28a. DATE OF (Month, D	ay, Year)		JURY M	1 🗆 Y	URY AT RK? (ES 2 NO	28d. DESCRI	BE HOW INJU	HRY OCCUREO	
L OR ATTENDING P DIRECTOR: After thours after death thours after death	ETED		Could not be determined	28s. PLACE O building,	F INJURY — etc. (Specify	Al home, farm,	etreet, factor	y, office	- I		N (Street and wn, State)	Number or Rura	I Route Number,
	COMPLE			CIAN: To the best of a									e(a) and manner ea stated.
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: It	TO BE	29b. SIGNATURE AND TITLE  29b. SIGNATURE AND TITLE  30. NAME AND ADDRESS OF	n	Walfers	RE OF BEAT	MD	- Orient		29c. LICENSE NU D12		141 - 100		
		Malter R 31. DAYE FILED (MORIT, DEK) APR 2 8 199	We 17	nt. M	D R'S SIGNAT	7600		rI	Or., To	wson.	MD 2	21204	,

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



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DIVISION OF VITAL RECORDS, P.O. BOX 68760.

HAT THE DING PHYSICIAN: The law requires that the death certificate be executed within a four death. Page 6 may be retained by the hospital or attending physician.	FINER CONTRACT RATE THIS CERTIFICATE has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	TANT II INDIA IS marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HIS	TO THE FINER	be filed within	IMPORTAGE
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	1 - FOR STATE REGISTRAR	STATE OF MARY			HEALTH AN	ID MENT	TAL HYGIEN	Ε		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DA	TE OF DEATH			. TIME OF DEATH
	ALGIMANTAS PETER	VITKAUSKAS	3				nth D	199	YEAR	7:45 A. M
	4. SOCIAL SECURITY NUMBER		E (In yrs. last birthday			DE 7 DA	TE OF BIRTH		8. BIRTHPL	ACE (State or Foreign
	214 58 8843	1 X M 2 □ F	42 YRS.	MONTHS DA	8 HOURS MI	Feb	onth, Day, Year)	53	Mary	land
- 1	9a. FACILITY NAME (If not institution, give s.	treet and number)	and number) 9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
OR	Stella Maris Hospice Towson Baltimore						re			
ᇈ	RESIDENCE OF DECEDENT									
DIRECTOR	Maryland 106. COUNTY N/A 10c. CITY,			ITY, TOWN OR LO		1timc	re		1	Od. INSIDE CITY LIMITS? YES 2 NO
BY FUNERAL	10e. STREET AND NUMBER				10f. ZIP CODE	21210	,			AT COUNTRY?
삘	3601 Greenway					21218	5	Un:	ited	States
5	11. MARITAL STATUS  1 X Never Married 2 Married	12. WAS DECEDENT EVEL FORCES? 1 X YE		13. WAS	ECENDENT OF HIS	SPANIC ORI	GIN? (Specify Yes	or No-	14. RACE -	- American Indian, White, atc.
≥	3 Widowed 4 Divorced	IF YES, GIVE WAR OF	DATES		ES 2 NO SE		to rincall, etc.)	- 1		White
	15. DECEDENT'S EDUC	CATION	I to DECEDENT	S USUAL OCCUP						
	(Specify only highest grade	completed)	(Give kind o	f work done during use retired.)	most of working	- 1	16b. KIND OF BUS	SINESS/IND	JSTRY	
7	Elementary/Secondary (0-12)	College (1-4 or 5 +)		nic Des			Art St	udio		
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)		-			NAME (FIN	st, Middle, Maiden	Sumamal	_	
	Stasis	Vi	tkauskas		Bro		a, midde, maideir	Surriame)	Valt	aite
BE	19e. INFORMANT'S NAME (Type/Print)		19b, MAILIN	G ADDRESS (Str	et and Number or Re	ural Route N	umber City or Town	n State Zin	Corle1	
2	Brone Vitkauskas		95-3	158 Paa	Place,	Mili	lani H	II 9	96789	
ı	20a. METHOD OF DISPOSITION 1 Burial 2 TyCremation 3 Remo		Ob. PLACE AND DAT	E OF DISPOSITION	(Name of	D	ATE 20c. LO	CATION C	City or Town	, Stata
	4 Donation 5 Other (Specify)		Green Moi	int Cre	natory	4/29/	'95 Ba1	timo	re, M	D
	21. SIGNATUBE OF FUNERAL SERVICE LIG	ENSEE			AND ADDRESS OF		Lohama	20 D	7	
	* State KING				A Steph					21286
	23. PART I. Enter the diseases, or o	Emplications that cause	ed the death. Do	not antar tha	7 Green	Past	ures Dr	. , Bo	TICIM	Approximata
	snock, or neart failure.	List only one cause on	aach lina.	THE CONTROL CITE	indua di aying,	aucii as c	ardiac or reapr	atory arre	rat,	Intarvai Between
ļ	IMMEDIATE CAUSE (Final disease or condition	AII	15							Onset and Death
i	resulting in death)	DUE TO (OR A)	S A CONSEQUENCE	OED:						Tyrs.
_	_		- H OUNGEOGENOE	J. j.						
TIFICATION	Sequantially list conditiona, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE	OF):						-
8	cause, Entar UNDERLYING									1
Ĕ	CAUSE (Disease or Injury that initiated aventa	DUE TO (OR A	A CONSEQUENCE	OF):						
	resulting in death) LAST	d								
CE	PART II. Other significant condition	e contributing to death	but not reculated	la Abana da d						
8						in Parti.	24a. WAS AN PERFOR		A	ERE AUTOPSY FINDINGS AILABLE PRIOR TO
ă	Capitaciero	ono Syper	-1000	e do	11177		1 - YES 2	NO		OMPLETION OF CAUSE F DEATH?
Σ	DID TODA CCO HIST CONTROL				<u> </u>		1	•	1	☐ YES 2 ☐ NO
A N	DID TOBACCO USE CONTR	RIBUTE TO CAUSE			UNCERT	AIN 🗆				
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER	HOSPITAL:	28. PLACE OF DE	OTHER:	he)					
₹	1 VES 2 NO  27. MANNER OF DEATH	1 Inpatiant 2 ER/O		4 - Nursing I	ome 5 Rasiden	<del>- 41</del>		lospi		
BY PHYSICIAN: MEDICAL	1 Natural 5 Pending	26a. DATE OF INJUR (Month, Day, Year		JURY	NJURY AT WORK?		DESCRIBE HOW IF	NJURY OCC	URED	
₩ .	2 Accident Investigation	22. 81.425.05.01.11		m 1	YES 2 NO					

26s. PLACE OF INJURY — At home, larm, street, factory, offica building, atc. (Specify)

281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

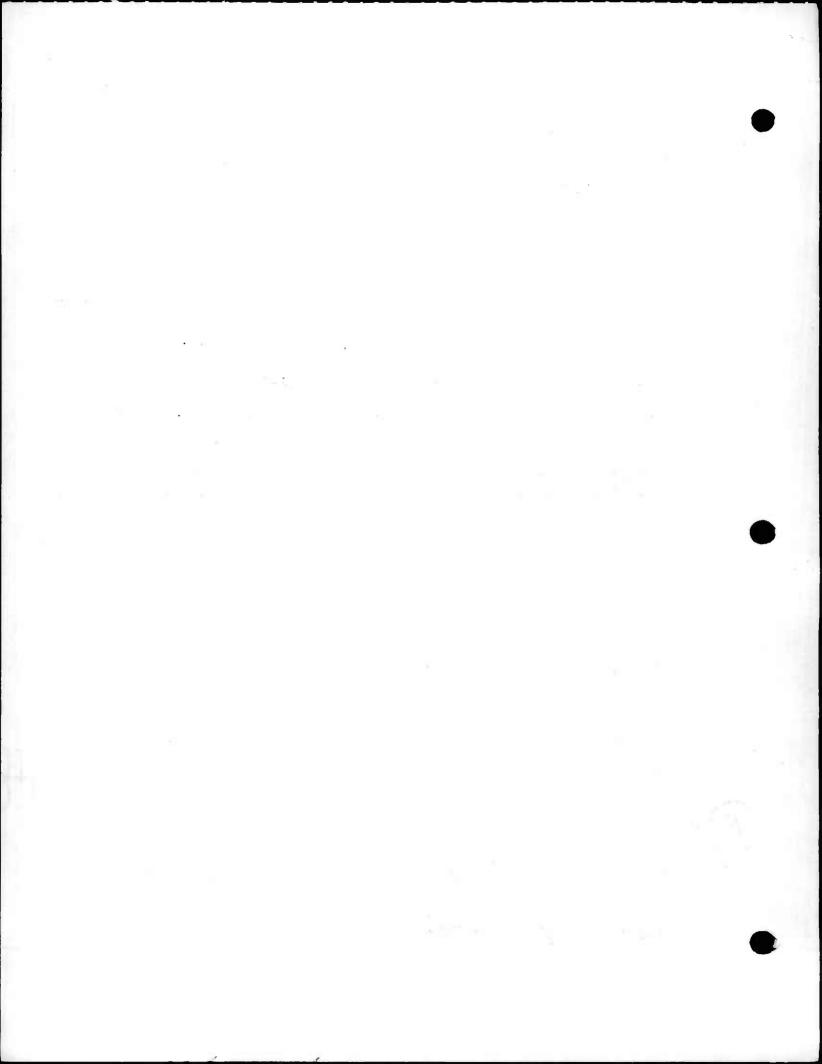
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER doll bullus

29c, LICENSE NUMBER D25643 29d. DATE SIGNED (Month, Day, Year) 14/26 195

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

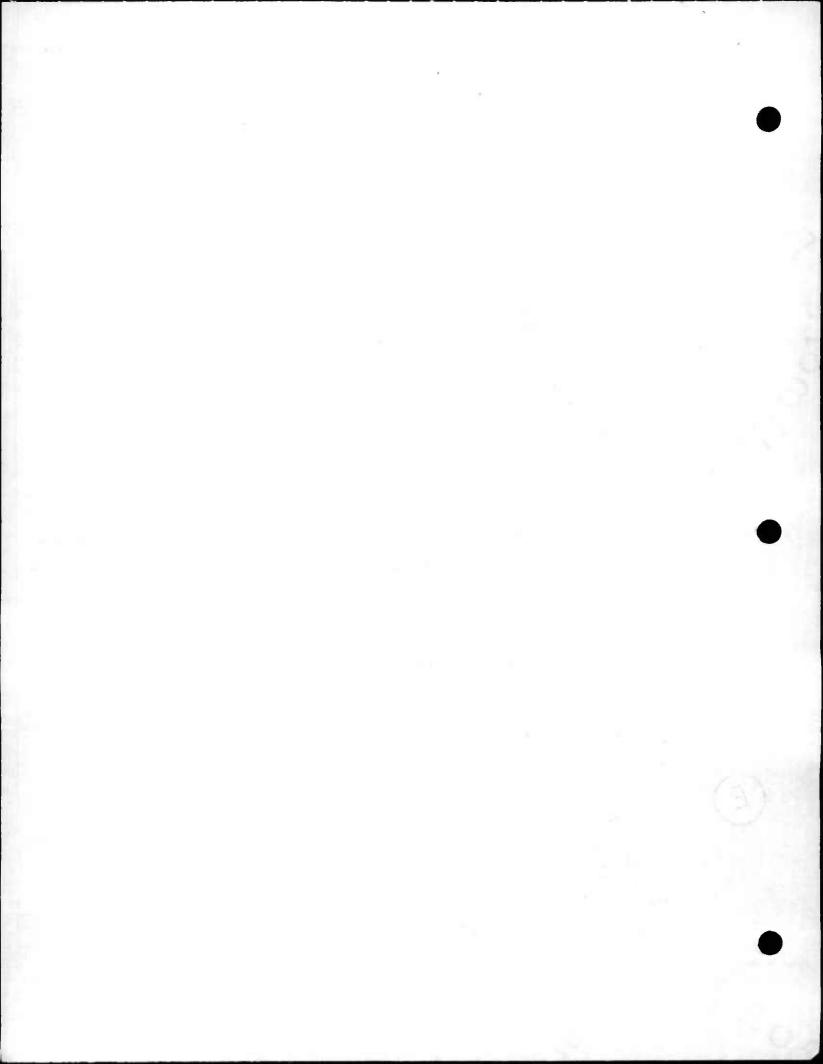
ULKNER 2300 DULANEY VALLEY RD. DR. KENDALL 1
31. DATE FILED (MONTH), DOX, YEAR
AFR 2 8 1995 FAULKNER TOWSON, MD 21204

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N OF VITAL RECORDS, P.O. BOX 68760	PHYSICIAN: The law rec
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		1 - FOR STATE REGISTRAR		STATE OF I	MARYLA	ND / DEPAR	TMENT	OF H	EALTH AND I	MENTAL HYGI				
)		1. DECEDENT'S NAME (First, M Chester	liddle, Last)	Warm	insk	e'				2. DATE OF DEATH	DAY	YEAR 3	TIME OF DEATH A	
Pir		4. SOCIAL SECURITY NUMBER 216-10-4653		5. SEX 1 XM 2 F	6. AGE (In 82	yrs. lest birthdey) YRS.	IF UNDER	DAYS	IF UNDER 24 HRS, HOURS MIN.	7. DATE OF BIRTH (Month, Day, You APRIL 2	r)	8. BIRTHPL Country) MARY	ACE (State or Foreign	
2, 3 should	TOR	9e. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL RESIDENCE OF DECEDENT					9b. CITY,		BALTIMORE		9c. COUNT		ORE CITY	
permit. Pages 1,	DIRECTOR		06. COUNTY	rimore		10c. CIT	Y, TOWN O		ONSVILLE				Od. INSIDE CITY LIMITS?	
**	FUNERAL	100. STREET AND NUMBER 715 MAIDEN C	ноісе	LANE -	606 P	.V.T.		101	21228				AT COUNTRY?	
iding physician.	BY	11. MARITAL STATUS  1 Never Married 2 Merried  3 Wildowed 4 Divorced  12. WAS DECEDENT EVER IN U.S. A FORCES? 1 VES 2 IF YES, GIVE WAR OR DATES					RMED  13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Ye if yes, specify Cuban, Mexican, Puerto Rican, etc.)  1  YES 2 NO Specify:					s or No 14. RACE American Indien, Black, White, etc. Specify: WHITE		
24 hours after death, Page 6 may be retained by the hospital or attending filled in by the funeral director, page 5 should be detached for use as the ion, or removal.	APLETED	15. DECEO (Specify only h Elementary/Secondary (0-12	)	ATION completed)  College (1-4 or 5 - 2—C		(Give kind of life. Do NOT u	work done a se retired.)	luring mo	ON st of working	DEPARTMENT OF AGRICULTUE				
d by the hos	BE COMPL	17. FATHER'S NAME (First, Midd STANLEY STAN		3						ME (First, Middle, Mei NA LOCKST				
ay be retained page 5 should be notified	5	DARLENE HIER	HOLZEF	2		1704	REY	FRIA	AR CHASE	- VIRGIN	Town, State, Zip C	H,VA	. 23456	
leath, Page 6 may funeral director, pa xaminer must t		29a. METHOD OF DISPOSITION 14 Buriel 2 Cremetion 4 Donation 5 Other (S) 21. SIGNATURE OF FUNERAL S	3 Remov		20b.P HUL	Y CARRYN	TY'acR	USSI	ANEORTH	¥4/29	ELKRIDO	-	, Stata	
ter death, Pag the funeral dii oval.		limo (f	1#	M			HU.	BBAF 07 V	VILKENS A	AL HOME, AVENUE-BA	LTIMORE		21229	
nted within 24 hours after completely filled in by the tal, cremation, or removal c event, the medical		23. PART I. Enter the diseases, or complications that ceused the deeth. Do not e shock, or heert feliure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):									espiratory arre	at,	Approximete interval Between Onset and Death	
h certificate be execunding physician and Hygiene prior to bur or other traumatives	CERTIFICATION	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  b. ACUTE C-T BLEED  DUE TO (OR AS A CONSEQUENCE OF):  C. DUE TO (OR AS A CONSEQUENCE OF):  d.												
a to	MEDICAL (	PART II. Other algorificant	PS'25	DM/	death but	not resulting	In the un	derlying	g ceuse given in	PER	AN AUTOPSY FORMEO?	CO	ERE AUTOPSY FINDINGS MAILABLE PRIOR TO DMPLETION OF CAUSE F DEATH?  YES 2 NO	
4: The law recate has been State Dept. or	SIAN:	DID TOBACCO USE 25. WAS CASE REFERRED TO B EXAMINER?	PEDICAL			DEATH YI	-		LUNCERTAIN	۷ 🗆				
PHYSICIAN: The law requires that this certificate has been signed by with the State Dept. of Health an riked, or Item 23 shows any	PHYSICIAN:	1 TYES 2 THO		HOSPITAL: 1 Inpatient 2 2 28a. DATE OF (Month, D	INJURY	28b. TIN	-	ing Home	e 5 🗆 Rasidence	8 Other (Specify) 28d. DESCRIBE HO	W INJURY OCCU	RED		
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A CONTRACTOR	COMPLET									io the ceuse(a) and				
TO THE HOSPITA TO THE FLINERAL De Sied within 72 IMPORTANT: II	BE CO	2 MEDICA 29b. SIGNATURE AND THE CO		On the basis of a	xamination a	ind/or investigation	n, in my of	olnlon, de	eath occured at the				onth, Day, Year)	
2 2 3	70	30. NAME AND ADDRESS OF	OHW WHO	COMPLETED CAUS	SE OF DEAT				0363		<b>&gt;</b> 4	145	25	
6		31. DATE FILED (Month, Day, Yea	1-AL	32. REGISTRA	R'S SIGNATI	3449	ز س،	lkan	s Ave	# 301 B	ALTO	2122	9	
		APR 2 8 199	5 Jul	of attended	rtando	14								



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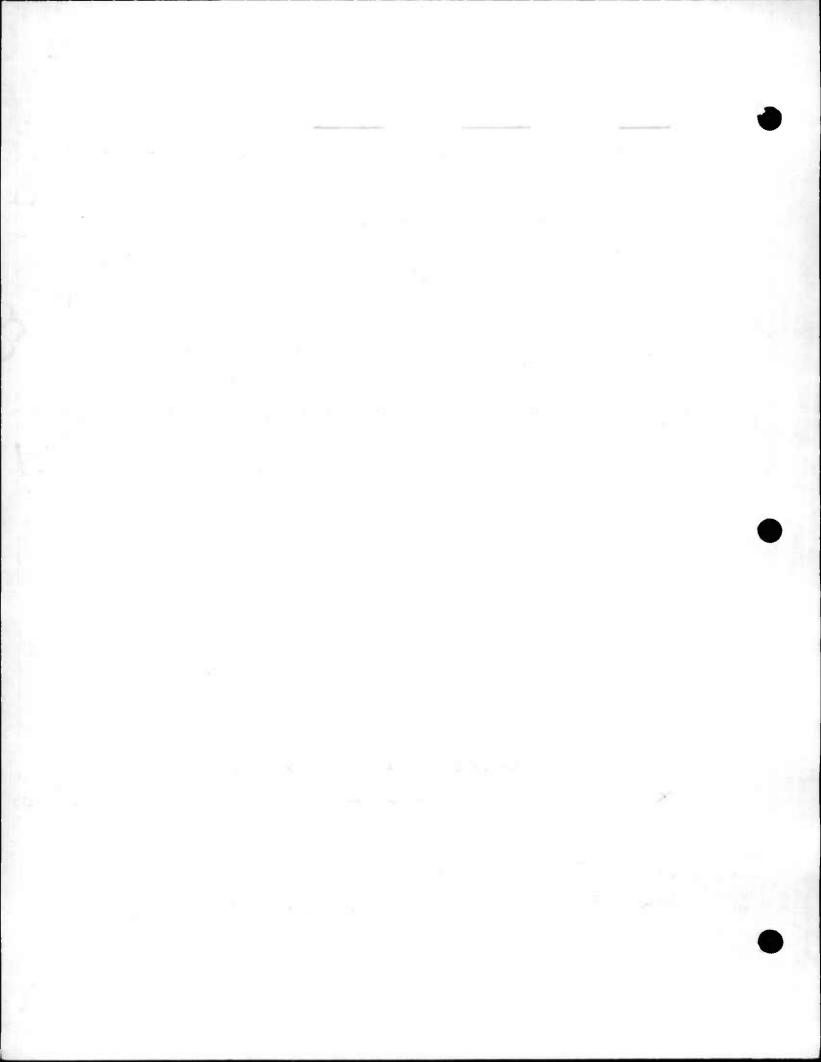
## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	_	1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO.
		1. DECEDENT'S NAME (First, Middle, Last) De Carlos E.B. Wallace April 24 1995 2025 M
		4. SOCIAL SECURITY NUMBER  5. SEX  6. AGE (In yrs. last birthday)  F UNDER 1 YEAR  F UNDER 24 HRS.  7. DATE OF BIRTH  6. BIRTHPLACE (Stafe or Foreign Of Month, Day, May)  7. DATE OF BIRTH  6. BIRTHPLACE (Stafe or Foreign Of Month, Day, May)  7. DATE OF BIRTH  7. DATE OF BIRTH  7. DATE OF BIRTH  7. DATE OF BIRTH  7. DATE OF BIRTH  8. BIRTHPLACE (Stafe or Foreign Of Month, Day, May)
Should	~	9e. FACILITY NAME (If not institution, give street end number)  9b. CITY, TOWN OR LOCATION OF DEATH  9c. COUNTY OF DEATH
1, 2, 3	ECTOR	Unit block N. Abington Ave. Baltimore N/H
if. Pages	DIR	19a. STATE 10b. COUNTY 19c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
physician. burial-transit permit.	ERAL	100. STREET AND NUMBER Abinaton Ave. 101. ZIP CODE 100. CITIZEN OF WHAT COUNTRY?
physician burial-tra	Y FUNER	11. MARITAL STATUS  12. MAS DECEDENT EVER IN U.S. ARMED 1 WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No- 1 Was Decembert of Nispanic Origin? (Specify Yea or No- 1 yes, apecify Cultin, Mexican, Puerto Rican, etc.) 1 yes, GIVE WAR OR DATES  13. WAS DECEMBENT OF NISPANIC ORIGIN? (Specify Yea or No- 1 yes, apecify Cultin, Mexican, Puerto Rican, etc.) 1 yes, GIVE WAR OR DATES  14. RACE — American Indian, 15 yes, apecify:  15 yes, Specify:  16 yes, Specify:
ttending e as the	ED BY	15. DECEDENT'S EDUCATION 168. DECEDENT'S USUAL OCCUPATION 166. KIND OF BUSINESSYINDUSTRY
pital or atte ed for use	<u> </u>	(Specify only highest grade completed)  [Give kind of work done during most of working life. Do NOT use retired.)  [Give kind of work done during most of working life. Do NOT use retired.]
by the hospit be detached at once.	COMPL	17. FATNER'S NAME (First, Middle, Lest) LOWENCE Walace  18. NOTHER'S NAME (First, Middle, Majden Surherne)  19. NOTHER'S NAME (First, Middle, Majden Surherne)
5 should by	38 6	190, INFORMANT'S NAME (Tupa@print)  190. MAILING ADDRESS (Street and Number, City or Town, State, Zip Code)
ay be ret page 5 s	임	Marya Brown Rt. Box 287A - George town, S. C. 29404
director, p		1 Description 3 Removal from State camelery, cremators of the place A Donation 6 Other (Specify)
funeral funeral		22. NAME AND ADDRESS OF FACILITY  JOSEPH L. RUSS Funeral Home  27.729 V. North Ave B. H. M. 17.17.17
d in by the or removal.		23. PART / Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.
E 00 B		IMMEDIATE CAUSE (Finsi disesse or condition  MILL + DIE GIROLAT INDIADO
executed within and completely fill, to burial, cremation, matic event, the		DUE TO (OR AS A CONSEQUENCE OF):
exect and to bur	CERTIFICATION	Sequentially list conditions, Due to (or as a consequence of):  If any, leading to immediate cause. Enter UNDERLYING
8 50.	TIFIC	CAUSE (Disease or Injury their Initiated events Due to (or as a consequence of):
		d.
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require sen sig of Hea	WE	1 N yes 2 NO
The law te has t ate Dept	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one)
certifica the Str , or it	HYSI	HOSPITAL: 1   Inpatient 2   ER/Outpetient 3   DOA   A   Nursing Home 5   Reeldence   Other (Specify) at scene  27. MANNER OF DEATH  280. DATE OF INJURY   28b. TIME OF   28c. INJURY AT   28d. DESCRIBE NOW INJURY OCCURED
er this ath with	BY PI	1   Netural 5   Pending   (Month, Day, Nar)   NAURY   266, DESCRIBE NOW INJURY OCCURED   1   YES 2   NO   SUBSTICE   SHOT
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the TO THE FUNERAL DIRECTOR: After this certificate has been signed by the be filed within 72 hours after death with the State Dept. of Health and MaIMPORTANT: If item 28 is marked, or item 23 shows any inju	TED E	3 Suicide 6 Could not be determined 286. PLACE OF INJURY — At home, ferm, street, fectory, office building, stc. (Specify) SIDEWALK 281. LOCATION (Street and Number or Rural Route Number, MO City or Town, State) WIT BLK. N. ARINGTON AND BALT
AL DIRECTOR AL DIRECTOR TO Thours	COMPLET	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated.
HOSPI FUNER within	S	2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the films, date end place, end due to the ceuse(e) end menner ee stated.  299 SIGNATURE AND TITLE OF SIGNED (Month Day Vier)
TO THE De fled	TO BE	0.C.M.E. April 25 1995
()		16. NAME AND ADDRESS OF REISON WIND COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  WARD GOLD TO MY 111 Penn Street, Baltimore, Maryland 21201
M		APR 2 8 1995 July Develor Reseally

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

DHMH-16 Rev 1/89



Pages 1, 2, 3 should permit. for use as the burial-transit the hospital or attending physician. should be detached urs after death. Page 6 may be retained in by the funeral director, page 5 should removal.

notified

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PHYSICIAN:

BY

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3 Suicide

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	DR	PIR	mo	Te Te
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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remo	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medica

95 13113 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH April 22, 1995 Joyce W. Seader 7:00 A. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH B. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. May 19, 216-32-5128 HOURS 67 1 M 2 X F YRS. 1927 England 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 502 Heath Ave. DIRECTOR Linthicum Anne Arundel RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Anne Arundel Linthicum 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10L ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 502 Heath Ave. 21090 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—II yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. RACE — American Indian, Black. White, etc. 1 Never Merried 2 Merried 1 YES 2 X NO Specify: specify: White BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Frederick Arthur Dunster Ethel Georgina Tily BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Ann Bond 502 Heath Ave., Linthicum, Maryland 21090 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State 1 Surley 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) Holy Cross Cem. Apr. 24, 1995 Brooklyn Park, Maryland 21. SIGNATURE OF FUNERAL SURVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Kirkley-Ruddick Funeral Home 421 Crain Hwy., S.E., Glen Burnie, MD 21061 23. PART 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. **IMMEDIATE CAUSE (Final Onact and Death** diseese or condition ute resulting in death) lacrodastin CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in deeth) LAST PART U-Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 1 NO OF DEATH?

1 TYES 2 NO

25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA ing Home 5 N Residence 6 Other (Specify)

1 TES 2 NO 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident

6 Could not be determined

26b, TIME OF M 28a. PLACE OF INJURY — At home, larm, street, factory, office building, etc. (Specify)

28c. INJURY AT WORK? 1 YES 2 NO

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

26d. DESCRIBE HOW INJURY OCCURED

29e. CERTIFIER
(Chack ank)
1 To CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end manner es stated. 2 MEDICAL EXAMINER: On the basis

nd/or investigation, in my opinion, death occured at the lime, data and place, and due to the cause(s) and manner as stated, 200: SIGNATORE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

D' 20 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

AREGISTRAP IGNATIVE

Erik L. Russell, M.D., 795 Oakwood Ra., Glen Burnie, Maryland 21061

▶ April 24, 1995

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Caras Justinianian

Pages 1, 2, 3 permit. page 5 should be detached for use as the burial-transit the hospital or attending physician. hours after death. Page 6 may be retained by in by the funeral director, removal. n and completely filled in by to bunal, cremation, or remo 6 requires that the death certificate be executed within physician signed by the attending physicial Health and Mental Hygiene prior

BALTIMORE, MARYLAND 21215-0020

t. of h has b ATTENDING PHYSICIAN: The law certificate I this with After ti after of

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**MINISION OF VITAL RECORDS, P.O. BOX 68760** 

95 13 14 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH CRAIG ANTHONY WILSON APRIL 1995 26, 4:45 Рм 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 F 32 216803282 11,1962 July MARYLAND 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR PRINCE GEORGES HOSPITAL CENTER CHEVERLY PRINCE GEORGES RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD BALTIMORE BALTIMORE 1 YES 2 X NO FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6203 MARGLENN AVENUE 21206 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No-RACE - American Indian, Black, White, atc. FORCES? Y YES 2 NO 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, atc.) В 1 TYES 2 NO Specify. Specify: 3 Widowed 4 Divorced WHITE COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) CONSTRUCTION COMMERCIAL PLUMBER 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) SAMUEL WILSON 품 BE JANET WAKELY notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Floute Number, City or Town, State, Zip Code) 9 BARBARA WILSON 6203 MARGLENN AVE BALTIMORE be MD 21205 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE must 1 Burlal 2 Committee 3 Removal from State
4 Donation 5 Other (Specify) netery, crematory or other place) 4/29 BALTIMORE, METRO examiner 21. SIGNATURE OF FUNERAL SERVICE DICEMBE 22. NAME AND ADDRESS OF FACILITY CVACH/ROSEOALE FUNERAL HOME 1211 CHESACO AVE 21237 medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such ea cerdiac or reapiratory arrest, Approximate ahock, or heart fellure. List only one cau Interval Between IMMEDIATE CAUSE (Final Onaat and Death the disease or condition resulting in death) Omero event, R AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events rasulting in deeth) LAST 0 injury, PART II. Other aignificant conditions contributing to death but not resulting in the undarlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL

1 | Inpatient OTHER: 1 X YES 2 NO XIXER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 5 27. MANNER OF DEATH 26c. INJURY AT 28d. DESCRIBE HOW INJURY marked whed 1 Natural YES BY 46 2 Accident Sulcide 28f. LOCATION (Str. 49 COMPLETED 6 Could not be ST PUCTFON 4 Homicide 28 determined 1  $\square$  CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) 2 X MEDICAL EXAMINER: On the basis of examination and/or ation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. THE TO THE DE FILES BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

ON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

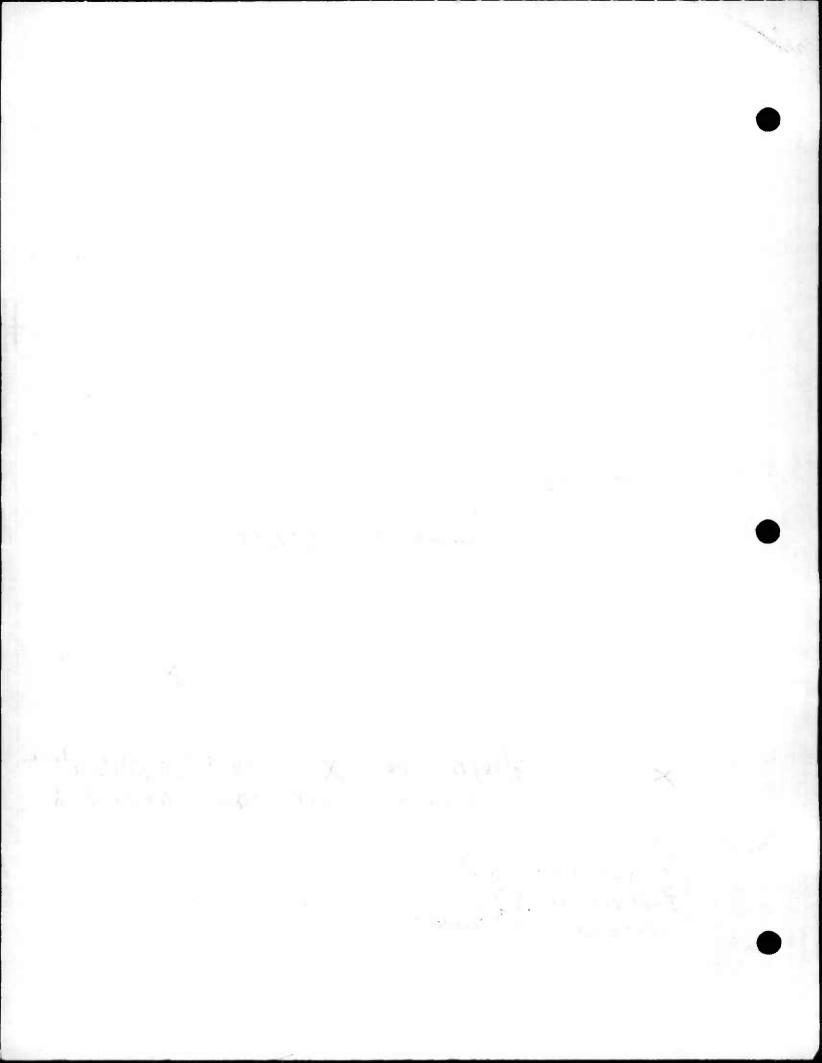
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APR 2 8 1995

O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

▶ APRIL 27,1995



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

	ITEMS: 20b, PER	F.H. FILM	G-723 5/1	/95 t.	. t					9!	5 1	3115
	1 - STATE REGISTRAR		MARYLAND A		RTMEN	T OF H	EALTH DEAT	AND I	MENTAL HYGI			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF GEATH			3. TIME OF DEATH
	Nancy Ala	ston							April	27	95	7:30 0H
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. le	st birthday)		Y	IF UNDER		7. DATE OF BIRTH (Month, Day, Year		8. BIRT	HPLACE (State or Foreign
	216-22-4698	1 🗆 M 2 🗓 页页	77	YRS.	MONTHS	DAYS	HOURS	MIN.	8-16-1	7	Coun	NC
	98. FACILITY NAME (If not institution, give street and number) 3904 Rosecrest St.				9b. CITY	, TOWN	R LOCATIO	ON OF DE	ATH	9c. CO	UNTY OF	DEATH
P.					В	alti	imor	e		1	n/a	
DIRECTOR	RESIDENCE OF DECEDENT  10e. STATE  10b. COUNT	,		I 400 OIT	Y, TOWN (	001001						
E	7	n/a		100, 011			nore					10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER						. ZIP CODE			Tree or		YES 2 NO
Z.	3904 Rosecrest	- AVA			21215					10g. C	IIIZEN OF	WHAT COUNTRY?
ž	11. MARITAL STATUS		T EVER IN U.S. AF	MED	12	WAS DEC				M	1	USA
BY FUNERAL	11. MARITAL STATUS  1 Never Merried 2 Merried  12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES			13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea If yea, specify Cuban, Maxican, Puarto Rican, etc.)  1 YES 2000 Specify:				Tea or No-	a or No— 14. RACE — American Indian, Black, White, atc.  Specify: Black			
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION		ECEDENT'S					16b. KIND OF	BUSINESS/II	NDUSTRY	
Fi	Elementary/Secondary (0-12)	College (1-4 or 5 s		ive kind of Do NOT u	work done se retired.)	during mo	st of workin	g				
MPL		1 yr.	1	Dome	stic	C				Home	MAk	er
Ö	17. FATHER'S NAME (First, Middle, Lest)	12-1					18. MOTH	IER'S NAI	ME (First, Middle, Maid	ien Surname)	)	
BE (	Henry Boone						E1	1a 1	Boone			
TO E	19a, INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS	S (Street a	nd Number	or Rural F	loute Number, City or	Town, State, 2	Zip Code)	
-	Gerald Wright			661	6 V:	ince	ent :	Lane	e apt.	301 1	Ba1t	o., MD 2121
	20g METHOD OF DISPOSITION 1 DEBurial 2 Cremation 3 Rem	ovet from State	20b. PLACE				me of		DATE 20c.	LOCATION -	- City or To	own, Stata
	4 Donation 5 Other (Specify)		- WOO	dlaw	n C	emet	ery	5/	2 4/2 1	book	lawn	, MD
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	D D A			Jame		. Mo	orton &			neral Home
_	· vaugra	- 200	and						ns St.			MD 21217
	23. PART I. Enter the diseases, or canonic shock, or heart failure.	omplications the List only one cau	t caused the de se on each line	eth. Do i	not enter	tha mo	de of dyle	ng, suct	a a cardiac or re	spiratory a	rrest,	Approximata interval Between
	IMMEDIATE CAUSE (Finel disease or condition	MM	11. M	m.l	. 7	0	A 10	0/	10			Onset and Death
	resulting in death)	a. MAZ DUE TO	4 Childre	107	7	1/	MC	119	<i>y</i>			276BR
_		DUE TO	(OR AS A CONSE	QUENCE O	F): {	,		•				
CERTIFICATION	Sequentially list conditions,	DUE TO	(OR AS A CONSE	DUENCE O	El-							
EK	If any, leading to immediate cause. Enter UNDERLYING		(4.7.10 ), 001102.	action of	. ,.							
Ĕ	CAUSE (Disease or Injury that Initiated events	OUE TO	OR AS A CONSE	OUENCE O	F):							
F	resulting in death) LAST	4										
- 1	DART II. Other elgoidlesst condition											
₹	PART II. Other significant condition	E contributing to	deeth but not r	resulting	In the un	nderlying	cause g	iven in i		AN AUTOPSY ORMED?	7 24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă	·								1 [] YES	2 1 NO		COMPLETION OF CAUSE OF DEATH?
M							/_		_			1 TYES 2 NO
Ÿ.	DID TOBACCO USE CONTI	LIBUTE TO CA					UNC	ERTAIN	1 🗆			
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEAT	TH (Check			/				
ΥS	1 TYES 2 TAN	1   Inpatient 2			4 🗆 Nun		5 0	Idenca	B Other (Specify)			
BY PH	27. MANNER OF DEATH  1   Natural 5   Pending 2   Accident Investigation	28a. DATE OF (Month, Da		28b, TIM	E OF IURY M	28c, INJU WOI 1 Y	JRY AT RK? ES 2 _	NO	28d. DESCRIBE HO	V INJURY O	CCURED	
	3 Suicide 8 Could not be 4 Homtolde determined	me, term, i					281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
COMPLET	29a, CERTIFIER				-		15111111					
MP	(Check only								to the cause(s) and n			
8			amination and/or	investigatio	n, In my o	pinion, de	ath occurs	d at the t	lime, date and place,	and dua to	the ceuse(	a) and menner as stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIER		14	./)			29c. LICE	NSE NUM	BER	29d. DA	TE SIGNED	(Month, Day, Year)
- 1	the tra	01.	an M	W			1//	(()	40		(	1191



MAY 01 1995

TO BE COMPLETED BY FUNERAL DIRECTOR

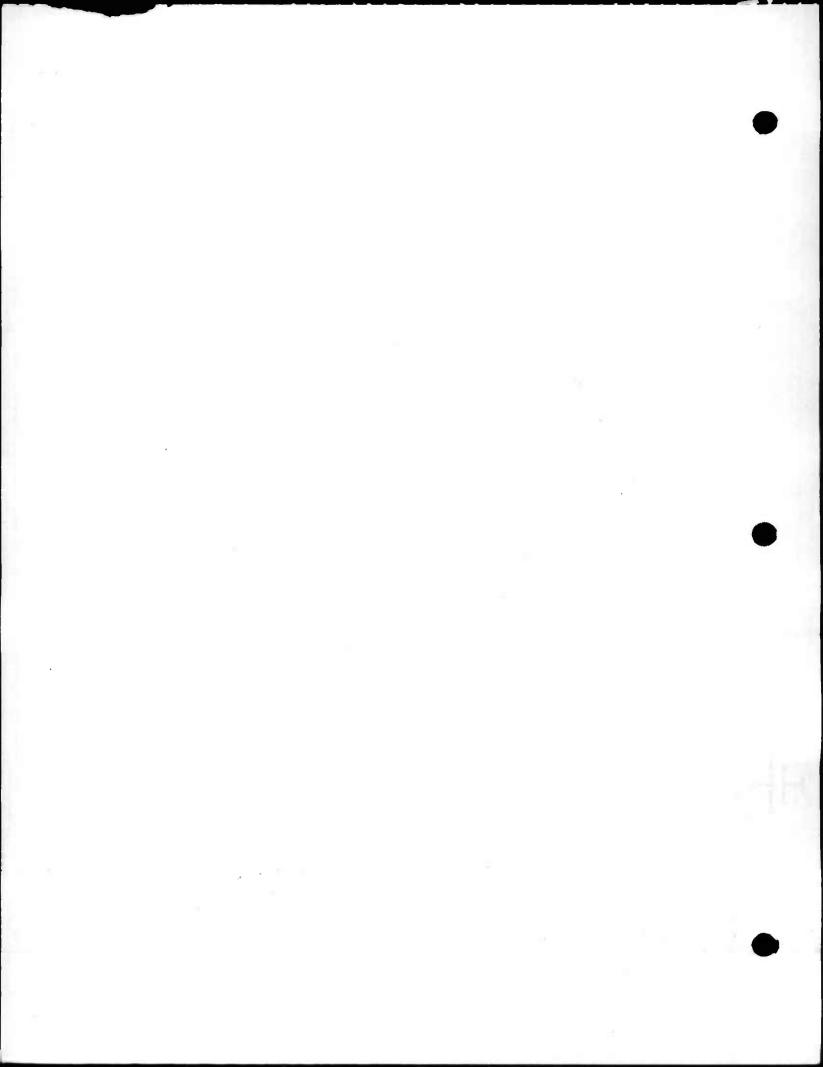
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE MOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within the flow steer death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR	STATE OF MARY		MENT OF HEA		NTAL HYGIENE		
1. DECEDENT'S NAME (First, Middle,	A.			2	DATE OF OEATH	VEAD	3. TIME OF DEATH
John Al	len Jr.			1	April 22	1995	6.02 Am
4. SOCIAL SECURITY NUMBER 219-68-7693	5. SEX 8. AGE		1	NAME AND	Month, Day, Year) 9-16-55	8. BIRT	HPLACE (State or Foreign try)
9a. FACILITY NAME (If not institution,		91	b. CITY, TOWN OR L	OCATION OF DEATI	н	9c. COUNTY OF	DEATH
LIBERTY MED	T		BALTI	MORE C	ITY	N/A	
MD 10a. STATE 10b. Co	N/A		OWN OR LOCATION ALTIMOR				10d. INSIDE CITY LIMITS? 1 YES 2 NO
10e. STREET AND NUMBER			10f. ZIP	COOE		10g. CITIZEN OF	WHAT COUNTRY?
920 MT. HOL				21229			S.A.
11. MARITAL STATUS  1 Never Married 2 Married  3 Widowed 4 Divorced	12. WAS DECEOENT EVER FORCES? 1 _ YES IF YES, GIVE WAR OR (	2 X NO	If yes, specify	PENT OF HISPANIC ( y Cuban, Maxicon, P NO Specify:	ORIGIN? (Specify Yes o Puarto Rican, atc.)	Ble	CE — Americen Indian, ok, White, atc.
15. DECEOENT'S (Specify only highest	B EDUCATION grade completed)	16a. DECEOENT'S USI	UAL OCCUPATION	working	16b. KINO OF BUSI	NESS/INDUSTRY	
Elementary/Secondary (0-12)	College (1-4 or 5+) N/A	LABORE	k done during most of stired.) R		FILTERI	TE COF	RP.
17. FATHER'S NAME (First, Middle, Las	st)		16.	MOTHER'S NAME	(First, Middle, Maiden S	urname)	
JOHN JACK	11222117	SR.		EDITH		TER	
19a. INFORMANT'S NAME (Type/Print) JOHN J. ALLE					te Number, City or Town,		
20a, METHOD OF DISPOSITION					BALTIMOR		
Mariel 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	Ramoval from Stata Cel	netary, cramatory or other	CEMETER	Y	4/27 LAN	SDOWNE	MD.
21. SIGHATORD OF FUNERAL SERVI	W Somai	tie	22. NAME AND A	ODRESS OF FACILI	"BETTS F LINE ST.	UNERAL BALTO	HOME ,MD21213
IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Adult Res	each line.				itory arrest,	Approximate interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST		a consequence of):  A consequence of):  Failure	2120				2 days
PART II. Other algnificant cond	ditions contributing to death I	out not reaulting in t	he underlying ca	iuse given in Par	24a. WAS AN A PERFORM	ED?	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 P NO
DID TOBACCO USE CO	ONTRIBUTE TO CAUSE C	F DEATH YES		UNCERTAIN I			
25. WAS CASE REFERRED TO MEDIC EXAMINER?	HOSPITAL:	26. PLACE OF OEATH (	Check only one)				
1 TYES 2 NO	1 Inpatient 2 - ER/Out		□ Nursing Home 5	☐ Realdence S ☐	Other (Specify)		
27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigs	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	Y WORK?	2 NO 28	d, DEŞCRIBE HOW IN.	SURY OCCURED	
3 Suicide 6 Could no 4 Homicide detarmin	building, atc. (Spe	f — At home, farm, stree cify)	el, tactory, office	28	tt. LOCATION (Street and City or Town, State)	d Number or Rural	Route Number,
	PHYSICIAN: To the beat of my know						
	AMINER: On the beals of examination	m and/or investigation, in					
Leone 2	With MI 1	1.D.	290	D41365	A S	April	22, 1995
30. NAME AND ADORESS OF PERSO	N WHO COMPLETED CAUSE OF DE	D. Z	600 Li	berty	Heights	Ave	21215
MAY 0 1 1995	32 REGISTRAR'S SIGN	ATURE					



1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH Rus-April 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS 90 215-28-8419 Jan.5,1905 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, gi 9b. CITY, TOWN OR LOCATION OF DEATH Nelchon DIRECTOR Baltimore 10e. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION City Maryland Baltimore completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, rial, cremation, or removal. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 1107 Woodheights Avenue 21211 hours after death, Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ∑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-if yes, specify Cuben, Mexicen, Puerto Ricen, etc.) BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Merried 1 TYES 2 NO NO Specify BY 3 X Widowed 4 Divorced COMPLETEL 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) 10 Seamstress Department Store 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Sumame) Ħ John Hobson BE Katherine Davis notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Wayne H. Appell 1107 Woodheights Ave. Baltimore, Maryland 21211 pe 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - CIF must cometery, cremetery or other place;
Hilltop Service Corp. 4/24 Towson, Ma medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 3631 Falls Road, Baltimore, Mar 23. PART I. Enter the diseases, a complicatione that caused the death. Do not anter the mode of dying, such se cerdiac or respiratory erres ehock, or heart feilure. List only one cause on each line. IMMEDIATE CAUSE (Final other traumatic event, the dieeese pr condition_ Netastatic carcin uma-untroumporma recuiting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760, DUE TO (OR AS A CONSEQUENCE OF) and com CERTIFICATION Sequentially liet conditione, DUE TO (OR AS A CONSEQUENCE DE): signed by the attending physician a Health and Mental Hygiene prior to if any, leeding to immediate ceuse. Enter UNDERLYING HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be in FUNERAL DIRECTOR: After this certificate has been signed by the attending physician within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to CAUSE (Disease or Injury DUE TO (OR AS A CONSEDUENCE OF): that initiated evente resulting in deeth) LAST 6 PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? any 1 YES 2 TO Shows a DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO Z PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 4 ID Nursing Home 5 - Residence 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 6 Other (Specify) 6 26e. DATE OF INJURY (Month, Day, Year) 27. MANNED OF DEATH 28 is marked, 28h TIME OF 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCUP INJUR 1 Natural м 1 YES 2 NO ВУ 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 261. LOCATION (Street and Number or City or Town, Stelle) 3 Suicide 6 Could not be COMPLETED 4 🗌 Homicide item 29e, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner se stated. FUNERAL I 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the d TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 1 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 01653

o/color

MAY 01

Paul Place

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

FOR STATE REGISTRAR

95 13117

.1995

9c. COUNTY OF DEATH

City

U.S.A

10g. CITIZEN OF WHAT COUNTRY?

Specify:

3. TIME OF DEATH

8:40 AM

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

White

1 X YES 2 NO

6. BIRTHPLACE (State or Foreign

Maryland

ATION — City or To	own, State				
on,Mary]	Land				
me					
	and 21211				
itory errest,	Approximate intervel Between Onset and Desth				
mony	3 months				
/					
UTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?					
	1 YES 2 NO				
IURY OCCURED					
d Number or Rural F	Route Number,				
er se stated.					
in the entre	e) end menner ee stated,				
DATE SIGNED					
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the duals perfilture be executed within 24 hours after dual. Page 6 may be retained by the hospital or attending physician to accompanie to the hospital or attending physician and the property of the property of the physician or attending physician and the physician or attending physician and the physician or attending physician and the physician or attending physician and the physician or attending physician and the physician or attending physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician	be fleet within 72 hours after death with the State Dept. of Heath and Mental Hydren prior to burial, committee, or removal.  IMPORTANT: If Hem 28 is marked, or Hem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
E HOSPITAL OR ATTI	d within 72 hours aft RTANT: If Item 28

2

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE . CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY 3. TIME OF DEATH YEAR HAZEL REBECCA BAILEY 4:00 P APRIL 1995 24. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday 7. DATE OF BIRTH (Month, Day, Year) 12-27-18 IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign DAYS 225-14-5817 1 M 2 X F 76 YRS. N.C. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 1719 CLIFTVIEW AVENUE RECTOR BALTIMORE CITY N/A RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY N/A ā BALTIMORE CITY XXYES 2 NO 104 STREET AND NUMBER FUNERAL 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 1719 CLIFTVIEW AVENUE 21213 u.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married B 3 X Widowed 4 Divorced BLACK COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a, DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 N/A HOUSEWIFE HOME once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) JAMES ROGERS notified at REBECCA STEPTOE BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 MARY FARMER 3114n CAMBRIDGE RD. BALTIMORE, MD. 21244 pe METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Must 1 M Burlat 2 ☐ Cremation 3 ☐ Removal from State ARBUTUS MEMORIAL PARK ☐ Donation 8 Other (Specify) 4/29 ARBUTUS, MD. examiner 21. SIGNATURE OF FUNERAL SERVICE 22. NAME AND ADDRESS OF FACILITY BETTS FUNERAL HOME 1129 N. CAROLINE ST. BALTO., MD21213 medical lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart re. List only one cause on each line. interval Betwe IMMEDIATE CAUSE (Final Onset and Death ä disease or condition_ cancer E MUL Smonths resulting in death) event. DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 mlury. PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? any 1 YES 2 NO Shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES NO UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item HOSPITAL: OTHER: 1 YES 2 NO 1 Inpatiant 2 ER/Outpatient DOA 6 4 Nursing Home 5 Rasidence 6 Other (Specify) 27, MANNEY OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural М BY 1 YES 2 NO 2 Accident Investigation 3 Suicide 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28 is 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide Hem 29a, CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as atteted. (Check only one) = MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and menner as stated. 296. SIGNATURE AND TITLE OF CENTE BE 29c. LICENSE NUMBE 29d. DATE SIGNED (Month, Day, Year)

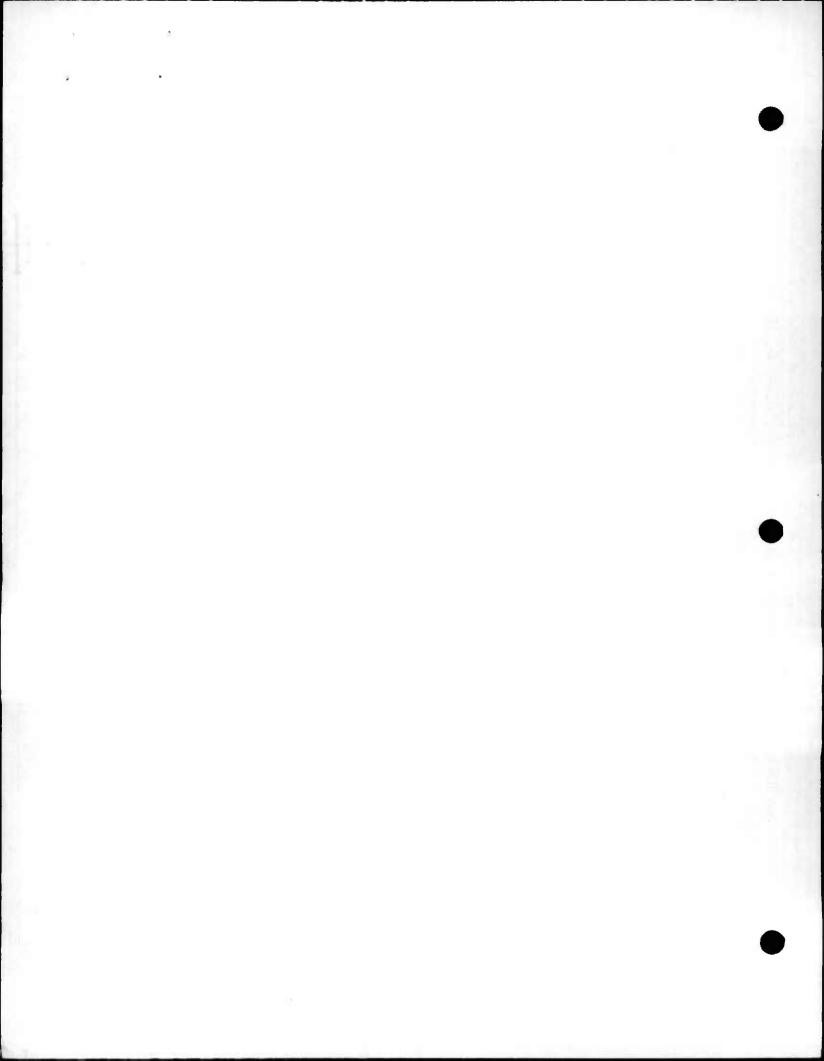
L7608

D5880

30. NAME AND AGDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

28

95



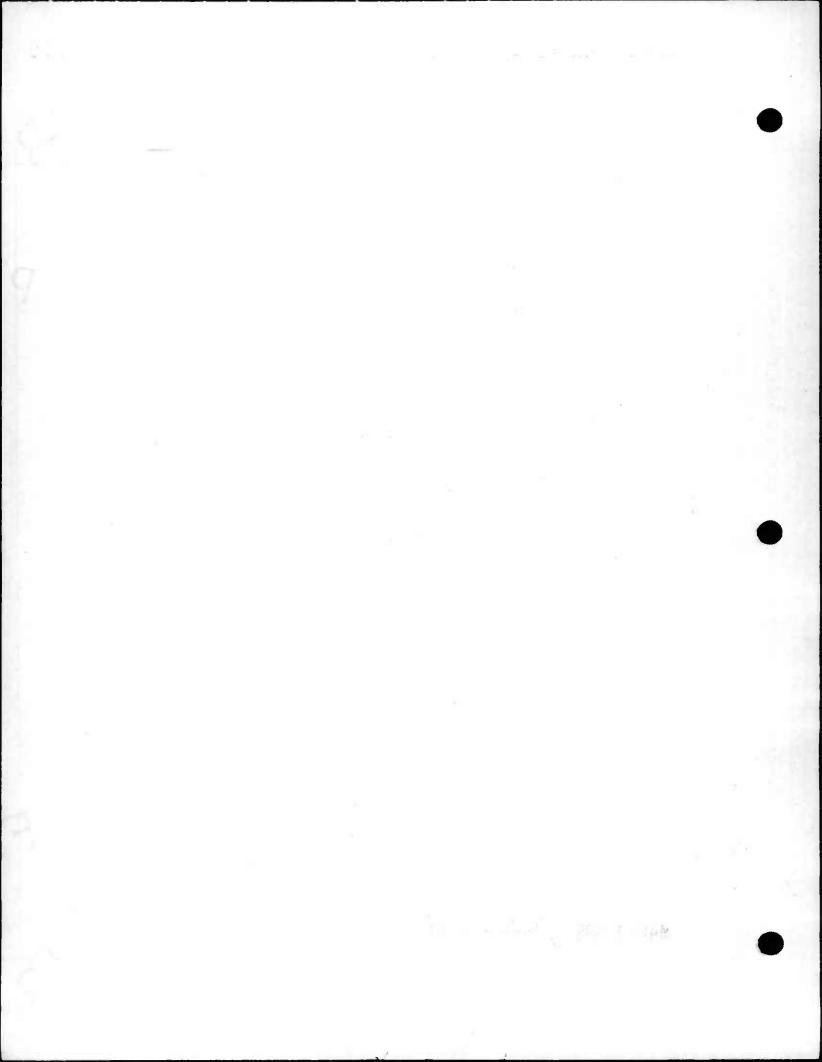
BALTIMORE, MARYLAND 21215-0020

BOX 68760 DIVISION OF VITAL RECORDS, P.O.

1 - FOR STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Bernice Berry 1:32 P April 27. 1995 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH 1922 FEB 24 19 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1922 219=10-9819 1 M 2 X F 73 DAYS HOURS 90. FACILITY NAME (If not institution, give street end number)
3600 W. Franklin Street Pages 1, 2, 3 should 9h. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Apt 3 A DIRECTOR Baltimore balto RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD BALTO BALTO 1 X YES 2 NO permit. FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3600 W. FRANKLIN ST APT 3A use as the burial-transit 21229 U.S.A hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 V NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexicen, Puerto Ricen, atc.)

1 YES NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO 1 X Never Married 2 Merried BY 3 Widowed 4 Divorced Specify: BLACK COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Sne detached for Elementary/Secondary (0-12) College (1-4 or 5+) 8TH N/A NURSE KESWICK NURSING HOME 17. FATHER'S NAME (First, Middle, Last) hours after death. Page 6 may be retained by the 18. MOTHER'S NAME (First, Middle, Meiden Surname) DIGGS BE ELIZABETH SMITH funeral director, page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 4304 PARKTON ST. BALTO, MD SHARON BERRY 21229 Pe 20s. METHOD OF DISPOSITION
X[X]Burlel 2 [] Cremetton 3 | Removal from State
4 | Donation 5 | Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must WESTERN THE TAR \$295 CATONSVILLE MD examiner OF FUNERAL SERVICE LA 22. NAME AND ADDRESS OF FACILITY March F/H West Home Wabash Avenue Baltimore, Md 21215 ion, or removal. 4300 Ja 0500 medicai 23. PART . Inter the diseases, or combilications that caused the deeth. Do not anter the mode of dying, such as cardiec or respiretory errest, ock, or heart failure. List only one cause on each line. Interval Between IMMEDIA CAUSE (Final Onset and Death completely filled the disease or condition metastatic gastre cancer 9 month event. resulting in death) DUE TO (OR AS A CONSEQUENCE OF): and com traumatic CERTIFICATION Sequentially list conditions, prior to DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING physician the death certificate be other t **CAUSE** (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events attending resulting in desth) LAST the atten Mental h PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS A Par AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? requires that any signed b 1 | YES 2 | 10 Shows 1 - YES 2 1 NO been f. of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN I PHYSICIAN: certificate has being the State Dept. The law r 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4 | Nursing Home 5 | Mesidence 8 | Other (Specify) 1 TES 2 NO HOSPITAL OR ATTENDING PHYSICIAN: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 0 27. MANNEB-OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? this c marked, 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending investigation 1 YES 2 NO BY After 2 Accident DIRECTOR: At hours after de item 28 is r 3 Sulcide 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECT DE filed within 72 hours at IMPORTANT; If item 2 29e. CERTIFIER (Check only 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner es stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 27.9 - MD 040850 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) YVONNE OTTAVIANO 900 CATON AVE BALTIMORE MD 212 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 01 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the nous after death. Page 6 may be retained by the hospital or attending physician.  TO THE FUNERAL OHECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.  IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Last)

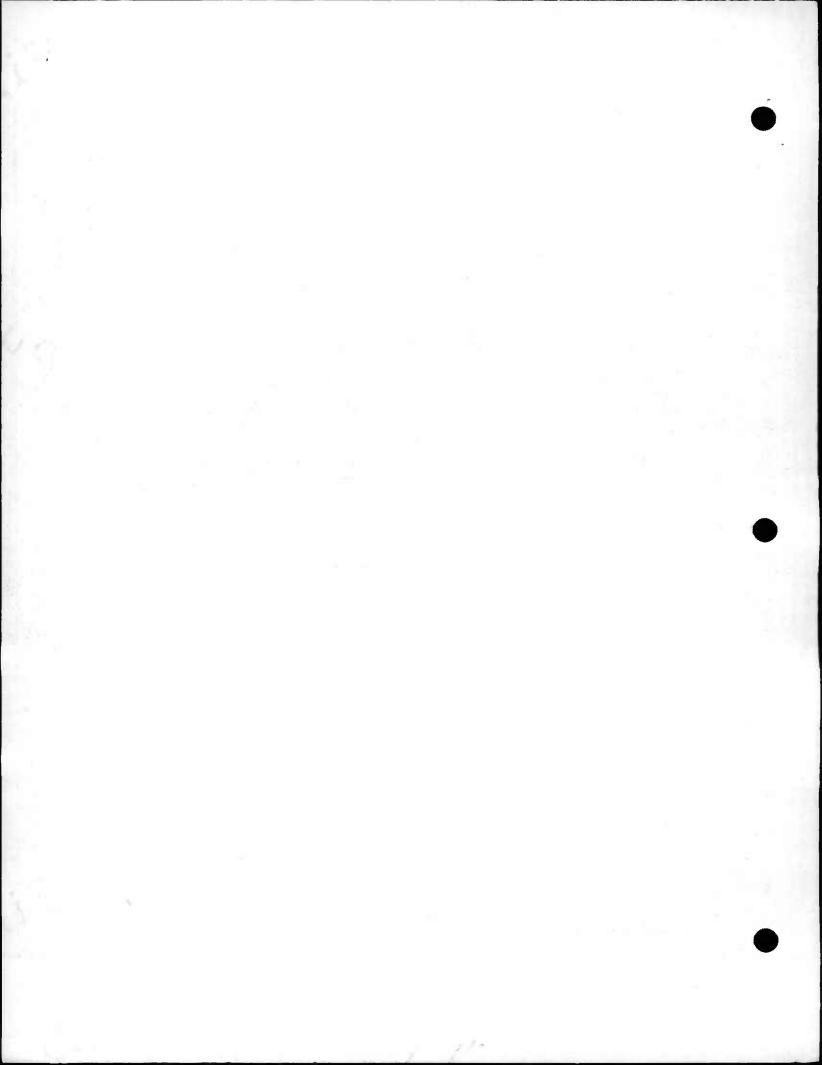
SMITHLEY L. BURNET

4. SOCIAL SECURITY NUMBER

5. SEX

6. AGE (In yrs. list birthdsy) | F UNDER 1 YEAR | F UNDER 24 HRS. | 7. DATE OF BIRTIN | 8. BIRTINPLACE (State

	1. DECEDENT'S NAME (First, Middle, Last) Smithey L. Burnett			ZEAR 3. TIME OF DEATH								
		UNDER 1 YEAR IF UNDER 24 HRS.		5 1:20 PM								
- 4	218-03-8112 1 XM 2 - F 82 YRS. MO	NTHE DAYS HOURS MIN.	(Month, Day, Year) 2/6/13	BIRTNPLACE (State or Foreign Country)								
~	9a. FACILITY NAME (If not institution, give street and number)  9b. CITY, TOWN OR LOCATION OF DEATN  9c. COUNTY OF DEATN											
<u>ō</u>	Mercy Medical Center, 301 St. Paul 19	Baltimore, MD	21202 Bal	tomore								
DIRECTOR	104 CATE 10b. COUNTY 3al to 10c. CITY,	OWN OR LOCATION		10d. INSIDE CITY IMITS?  1 YES 2 NO								
FUNERAL	100 STREET AND NUMBER Mosher St.	101. ZIP CODE 2 2	6 10g. CITIZE	NOF WHAT COUNTRY								
BY	11. MARITAL STATUS  11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 A YES 2 NO IF YES, GIVE WAR OR DATES  13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— If Yes, apacity Suban, Maxican, Puerto Rican, etc.)  14. RACE — American Indian, If yes, apacity Suban, Maxican, Puerto Rican, etc.)  15. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— If Yes, GIVE WAR OR DATES)  16. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— If Yes, Specify)  17. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— If Yes, Specify)  18. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— If Yes, Specify)  19. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— If Yes, Specify)  19. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— If Yes, Specify)  19. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— If Yes, Specify)  19. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— If Yes, Specify)  19. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— If Yes, Specify)  19. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— If Yes, Specify)  19. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— If Yes, Specify)  19. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— If Yes, Specify)  19. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— If Yes, Specify)  19. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— If Yes, Specify)  19. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— If Yes, Specify)  19. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— If Yes, Specify)  19. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— If Yes, Specify)  19. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— If Yes, Specify)  19. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— If Yes, Yes, Yes, Yes, Yes, Yes, Yes, Yes,											
COMPLETED	Elementary/Secondary (0-12) College (1-4 pr 5+)	done during most of working hired.)	16b. KIND OF BUSINESS/INDUS	vices admi								
	17 TATHER'S NAME (First, Middle, Last)		E (First, Middle, Myliden Surname)	VICES CIGINIA								
TO BE	199_INSORMANT'S HAME (Type/Print) (199_MAILING AD	DRESS (Street and Number or Rural R	oute Number, Pity or Town, State, Zip Co	14-1								
	20a METHOD OF DISPOSITION 200 PLACE AND DATE OF D	DISPOSITION /Name of		y or Town, Stata								
	Burial 2 Cremation 3 Ramoval from State canethry Frenciory or other Donation 6 Other (Specify)	22 NAME AND ADDRESS OF FAC	3/2/95 Hrbu	tus, nd								
	· Glupnia D. Scott	Tarch fi	H-West Ar	je i								
	23. PART & Enter the disease, or complications that caused the death. Do not shock, or heart fellure. List only one cause on each line.	enter the mode of dying, such	es cerdiac or raepiratory arree	t, Approximate Interval Between								
	IMMEDIATE CAUSE (Final disease or condition Motoday)	La /8-100 -	= + 0	Onset and Death								
	disease or condition resulting in death)  a. //etq+a+c   Cancaci DUE TO (OR AS A CONSEQUENCE OF):	tic/Biliary -	tract Carcine	oma gr								
N		inoma		10 403								
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING											
FI	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):											
E	resulting in death) LAST											
	PART II. Other algnificent conditions contributing to death but not resulting in the	he underlying cause given in F		24b. WERE AUTOPSY FINDINGS								
EDICAL	Hypercoagulable state		PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?								
ME			_   (	1 _ YE\$ 2 _ NO								
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF I	DEATH YES NO 26. PLACE OF DEATH (Cho	A 1									
SICI	EXAMINER? HOSPITAL:	THER:  Nursing Home 5 Residence 4										
PHYSICIAN	27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 19.11 IRV	F 28c. INJURY AT	28d. DESCRIBE NOW INJURY OCCUP	RED								
BY	1 Natural 5 Pending 2 Accident Investigation	M 1 YES 2 NO										
COMPLETED	3 Suicide 6 Could not be 4 Nomicide datarmined 26a. PLACE OF INJURY — At homa, farm, atree building, etc. (Specify)	et, factory, office	28f. LOCATION (Street and Number or City or Town, State)	Rural Route Number,								
34	CERTIFIER Check only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at	it the time, data and place, and due t	o the cause(a) and manner as stated.									
ò	MEDICAL EXAMINER: On the beals of examinetion and/or investigation, is	n my opinion, death occured at the t	lme, date and place, and due to the o	cause(a) and manner as stated.								
BE	Seven J. Hanney, M.D., ph	ysician PO 81	75 29d. DATE S	IGNED (Month, Day, Year)								
0	Mercy Medical Center, 301 St.	Paul, Baltin	note MD 2	1202								
	MAY U 1 1995											



TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10e. STREET AND NUMBER  17 Treeway Court  11. MARITAL STATUS  1 Never Married 2 X Merried  3 Widowed 4 Divorced  15. DECEOENT'S ED (Specify only highest grace)  Elementary/Secondary (0-12)  12	street and number) cal Center  TY  Limore  12. WAS DECEDENT FORCES? 1 IF YES, GIVE WAI	8. AGE (In yrs. las 83 EVER IN U.S. AR	YRS.	IF UNDER MONTHS	TOWN	IF UNDER HOURS	MIN.	7. DATE OF (Month, D	lay, Year)	1911 9c. COU	Countr	nsylvania
159-09-2341  9a. FACILITY NAME (If not Institution, give Saint Joseph Medical Residence of Decement 10a. STATE 10b. COUNT 10b. STREET AND NUMBER  17 Treeway Court 11. MARITAL STATUS 1 Never Married 2 X Merried 3 Wildowed 4 Divorced  15. DECEMENT'S EDISPORTY Only highest grace Elementary/Secondary (0-12) 12	street and number) cal Center  TY  imore  12. WAS DECEDENT FORCES? 1 IF YES, GIVE WAI	83  EVER IN U.S. AR  YES 2 元  Place of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the	YRS.	9b. CITY	TOWN	OR LOCATION N	MIN.	Novembe EATH	lay, Year)	9c. COU	Per	nsylvania
Saint Joseph Medical Residence of Decement 10e. STATE 10b. COUNT 10e. STREET AND NUMBER 17 Treeway Court 11. MARITAL STATUS 1 Never Married 2 X Merried 3 Wildowed 4 Divorced 15. DECEMENT'S ED (Specify only highest grade Elementary/Secondary (0-12) 12	#1-C  12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WAI	YES 2 X		Y, TOWN C	OR LOCA	on, N		EATH	<u>- u,</u>	9c. COU	NTY OF D	EATH
10e. STATE  Maryland  10e. STREET AND NUMBER  17 Treeway Court  11. MARITAL STATUS  1 Never Married 2 X Merried  3 Wildowed 4 Divorced  15. DECEOENT'S ED (Specify only highest grad Elementary/Secondary (0-12) 12	#1-C  12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WAI	YES 2 X				TION						
Maryland Balt  10e, STREET AND NUMBER  17 Treeway Court  11. MARNITAL STATUS  1 Never Married 2 X Merried  3 Widowed 4 Divorced  15. DECEOENT'S ED (Specify only highest grace)  Elementary/Secondary (0-12)  12	#1-C  12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WAI	YES 2 X				HUN						
10e. STREET AND NUMBER  17 Treeway Court  11. MARITAL STATUS  1 Never Married 2 X Merried  3 Widowed 4 Divorced  15. DECEOENT'S ED (Specify only highest grace)  Elementary/Secondary (0-12)  12	12. WAS DECEDENT FORCES? 1 I	YES 2 X									ł	10d. INSIDE CITY LIMITS? 1 YES 2 X NO
11. MARITAL STATUS  1 Never Married 2 X Merried  3 Widowed 4 Divorced  15. DECEOENT'S ED (Specify only highest grace)  Elementary/Secondary (0-12)  12	12. WAS DECEDENT FORCES? 1 [ IF YES, GIVE WAI	YES 2 X			-	f. ZIP COO	E			t0g. CIT	IZEN OF W	WHAT COUNTRY?
1 Never Married 2 X Merried 3 Wildowed 4 Divorced  15. DECEOENT'S EDISpecify only highest grace Elementary/Secondary (0-12) 12	FORCES? 1 IF YES, GIVE WAI	YES 2 X				21286					ted S	States
(Specify only highest grad Elementary/Secondary (0-12) 12		H OR DATES			If yes, sp	CENDENT O ecify Cuba 3 2 X NO	n, Maxica	NIC ORIGIN? ( in, Puerto Rici y:	Specify Yes in, atc.)	or No—	14. RACE Black Specif	- American Indian, white, atc.
12	UCATION le completed)	16a. DE	CEDENT'S	USUAL OF	CCUPATION TO THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE C	ON ost of workin	a a	16b, KI	ND OF BUS	SINESS/IN	DUSTRY	
	College (1-4 or 5+)		nemal					Ow	n Ho	me		
17. FATHER'S NAME (First, Middle, Last) OSCAR Magnus Lea	forcen							ME (First, Mide	,	/		
19a. INFORMANT'S NAME (Type/Print)	rgreen	196	b. MAILING	ADDRESS	S (Street s			arah E		0	Codel	
James L. Bennett		1	7 Tre	eeway	7 Co	urt 1	1-C	Balt	imor	e, M	212	:86
26a. METHOD OF DISPOSITION 1 Burlat 2 X Cremation 3 Ren	noval from State	20b. PLACE A				eme of		DATE		CATION —		
4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE L.	ICENSEE	Green		Cre	mate	Dry ND ADDRES		4/29	Ba	ltim	ore,	Maryland
Ster-T.	Butt-			M	litc	hell-	Wie	defeld ad Bal	Home	e, Ir	nc.	21.2
disease or condition resulting in death)  Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING	ATRIAL F	OR AS A CONSEC	ON	F):								1 HOUR
CAUSE (Disease or Injury that Initiated events resulting in death) LAST	d	OR AS A CONSEC										
PART II. Other significant condition ISCHEMIC HEART COLON CARCINON	DISEASE	eeth but not r	esulting i	In the un	derlyin	g ceuse g	iven in		PERFOR	MED?		WERE AUTOPSY FINDING AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES NO
DID TOBACCO USE CONT	RIBUTE TO CAU					( UNC	ERTAIN	۷ 🗆				
25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL:		E OF DEAT	OTHER	₹:							
27. MANNER OF DEATH	1 Inpetient 2 LE	JURY	28b. TIM	E OF	28c. INJ	URY AT	sidence	6 Other (S)		NJURY OC	CUREO	
Netural 5 Pending 2 Accident Investigation	(Month, Day,	. Year)	INJ	URY M		RK? YES 2	NO					
3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF I building, etc	INJURY — At hor c. (Specify)	me, farm, s	street, facto	ory, offic	•		28f. LOCATIO	ON (Street a own, State)	nd Number	or Rural A	oute Number,
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYS												and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIE		~~~				29c, LICE D 16	NSE NUM					(Month, Day, Year)
JAMES H BIDDISON					wsc	N,MA	RYL	ND 21	204		101	
31. OATE FILEO (Month, Day, Year)	32. REGISTRAR									-		

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, par	he filed within 70 hours after death with the State Dent of Health and Mental Horlene prior to hurial premation or semanal
	H	王	file
	2	2	Ž

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

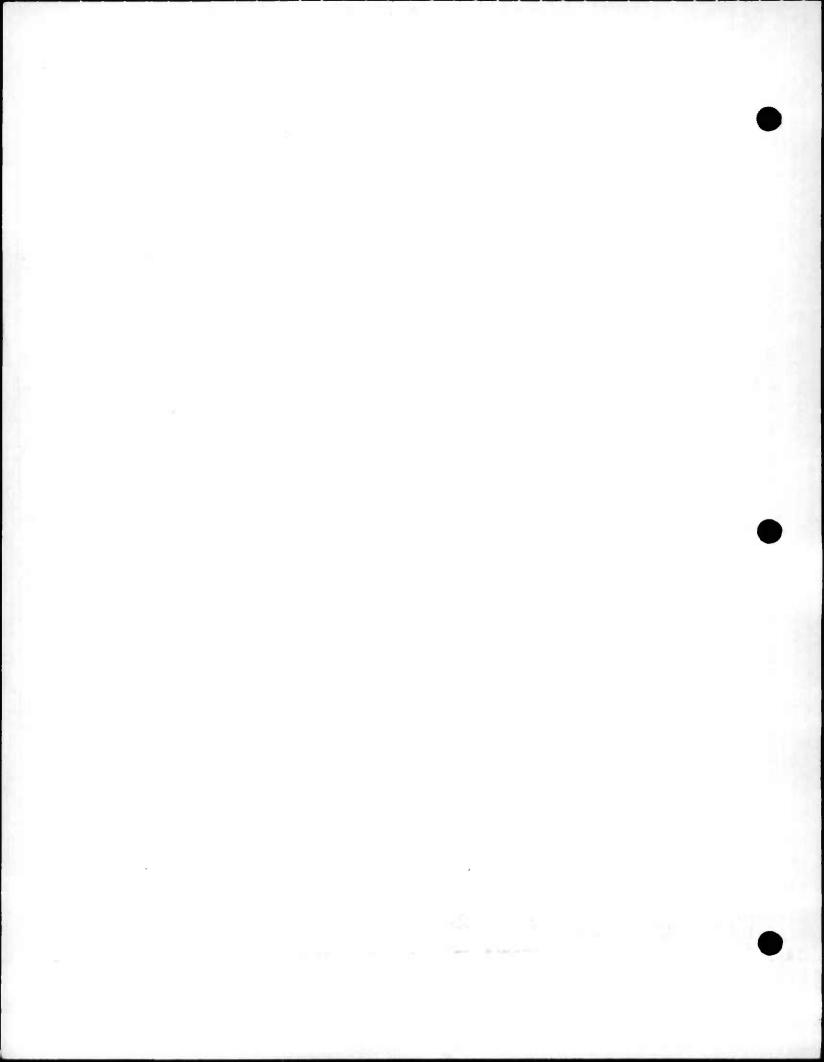
CERTIFICATE OF DEATH

REG. NO.

RECEDENT'S NAME (First, Middle, Last)

ARY R RTRD

		1. DECEDENT'S NAME (First	, Middle, Last)									2. DATE OF DEATH		3	. TIME OF DEATH
		MARY B. BIR	D									APRIL 2	Ž, 19	95	1:00 P. M
		4. SOCIAL SECURITY NUME	BER	5. SEX	8. AGE (In	yrs. last bi	irthday)	IF UNDER	t YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH	, ,		ACE (State or Foreign
		219-18-3269		1 □ M 2 🔯 F	71	1,000	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year)	24	Country)	
		9a. FACILITY NAME (If not in	stitution, give s	treet and number)				9b. CITY,	TOWN (	OR LOCATI	ON OF DE	JAN. 17, 19		OHIO	
	DIRECTOR	719 MAIDEN CHOICE LANE-HR-343 CATONSVILLE MARYLAND													
	EC	10a. STATE	10b. COUNTY	,			10c. CITY	, TOWN O	R LOCAT	TION				14	0d. INSIDE CITY
	E	MARYLAND	BAL	TIMORE						SVILI	E			- 1	LIMITS?
	FUNERAL	100. STREET AND NUMBER 719 MAIDEN	CHOICE	LANE -	HR-34	43			101	ZIP CODE					AT COUNTRY?
	BY FUN	11. MARITAL STATUS 1 Never Merried 2 3 Nidowed 4 Divo	Married	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	T EVER IN U	U.S. ARME 2 NO	ED .	1	f yes, sp	ENDENT Cube	n, Mexice	IIC ORIOIN? (Specify Yer n, Puerto Rican, etc.)		14. RACE -	- American Indian, White, atc. WHITE
	0		EDENT'S EDU	TATION .				1							WILLE
	ETE	(Specify only	y highest grade	completed)		(Give	kind of we NOT use	ork done o	during mo	ON ost of worldr	g	166. KIND OF BU	SINESS/IND	USTRY	
ಪ	COMPLE	Elementary/Secondary (0 12TH GRADE	-12)	College (1-4 or 5		HOME						HOME	MAKIN	iG	
at once.	E COI	17. FATHER'S NAME (First, M. FRANCIS LEO		EY						18. MOTI		ME (First, Middle, Maiden RA HENNING:			
notified	TO B	190. INFORMANT'S NAME (7) MR. FRANCIS				19b. N	AILINO A	ADDRESS	(Street a	nd Number	or Rural F	PASADENA,	n, State, Zip	Code)	
9		20a. METHOD OF DISPOSITI			1	_		_			1				
must	į.	1 Donation 5 Other	n 3 🗆 Reme	oval from State		PLACE AND LOTY, Cromel EN HA						4/25 GLE		Olty or Town	, State
ner		21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE	TOBL			22.1	NAME AN	ND ADDRES		CILITY		1112	
examiner must		→ 71/7/	eal	Cole	س	1						AL HOME IN	- •	F MD	21220
or removal		23. PART I Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, ehock, or heart failure. List only one cause on each line.  Approximate interval Retween													
event, the me		immediate Cause (Fin disease or condition resulting in death)	bert failure.	List only one cau	se on eac	ch line.						ling ca.			Interval Between Onset and Death
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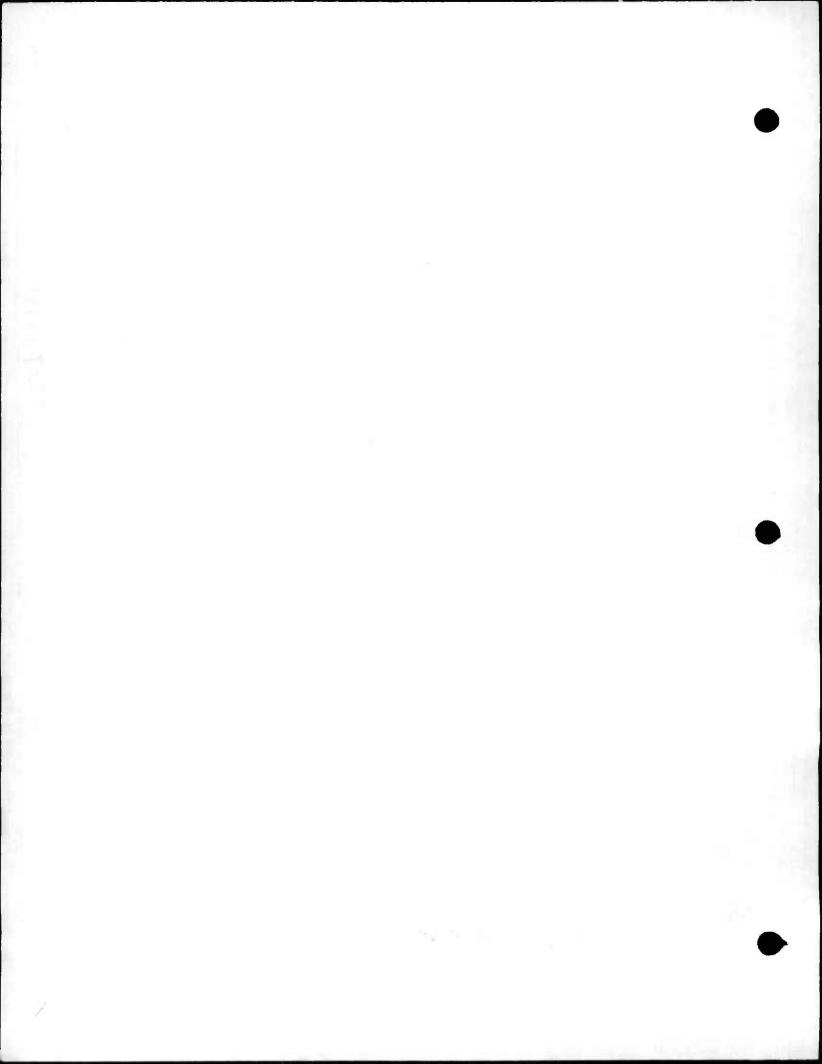


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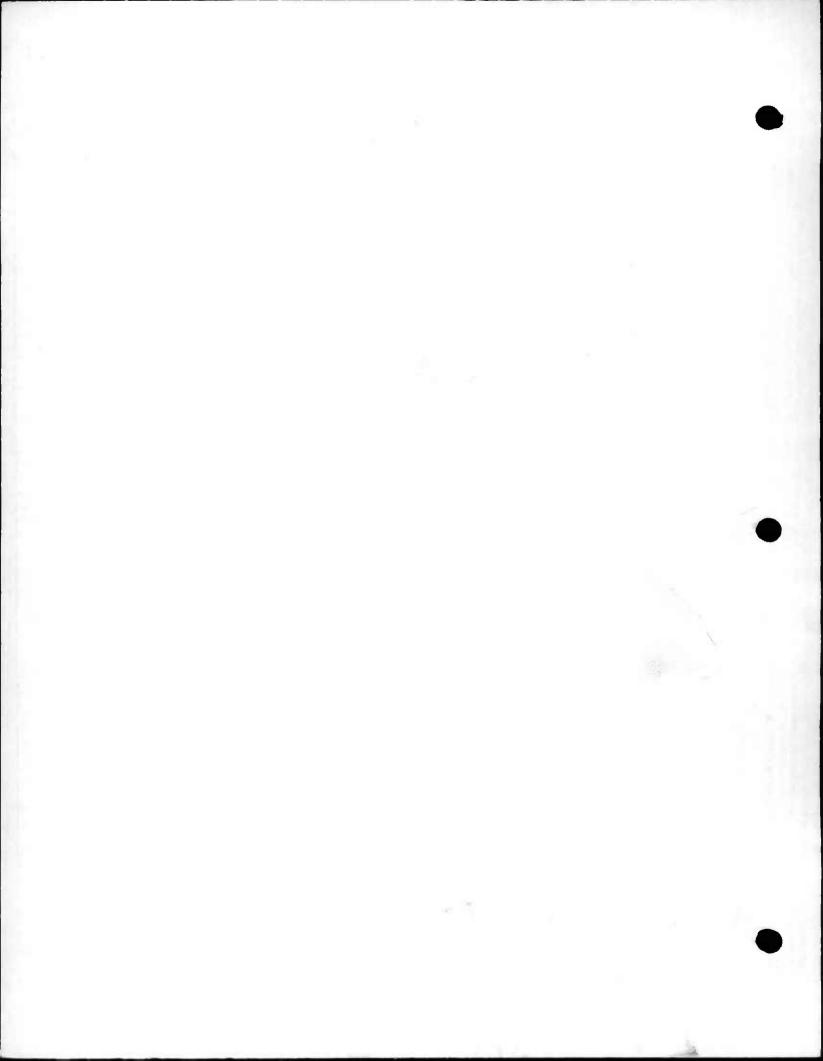
TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

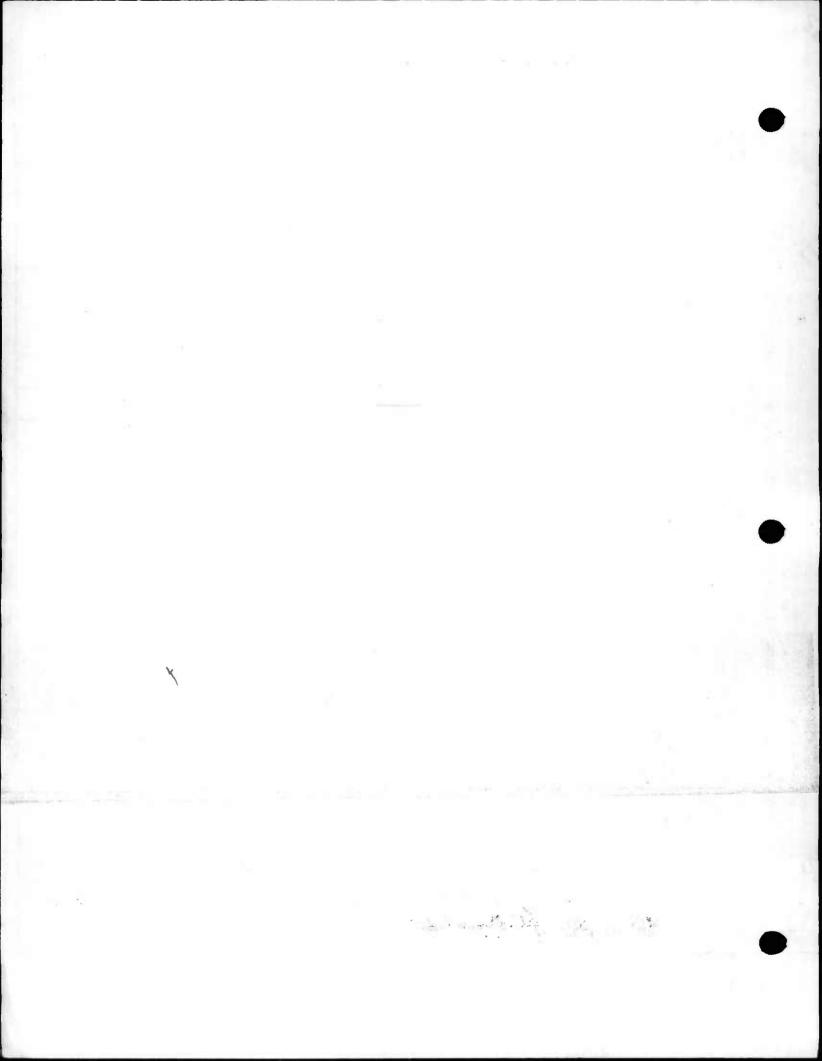
FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL I	HYGIENE
REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

1 - STATE STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.														
	1. DECEDENT'S NAME (First, Middle, Lest)		/					2. DATE OF DEATH MONTH DAY YEAR				3. TIME OF DEATN		
	MELVIN		CAMERON							PRIL 26,199		25	4:15 P	
,	4. SOCIAL SECURITY NUMBER 213-09-3886	5. SEX	6. AGE (In yrs. las	4 yrs.	MONTHS	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE O	F BIRTN Day, Year) 1-11		8. BIRTN Countr	PLACE (State or Foreign	
	96. FACILITY NAME (If not institution, give atm		- 04	-j tna.	Oh CITY	TOWAL C	R LOCATIO	ON OF DE		1-11	Lavani		N.C.	
Ä	313 ALLENDALE		200											
5	RESIDENCE OF DECEDENT					BALTIMORE CITY N/A							A	
DIRECTOR	10a. STATE 10b. COUNTY MD N/A				BALTIMORE CITY							10d. INSIDE CITY LIMITS?		
	10e. STREET AND NUMBER						ZIP CODE		1		10m CIT	TZEN OF W	1 YES 2 NO	
FUNERAL	313 ALLENDALE STREET							21229 U.S.A.						
FU	11. MARITAL STATUS  1 Never Married 2 Married	EVER IN U.S. AR	YES 2 X NO If yes, specify			AS DECENDENT OF HISPANIC ORIGIN? (Specify es, specify Cuben, Mexican, Puerlo Rican, etc			IC ORIGIN? (Specify Yes or No-			14. RACE — American Indian, Black, White, atc.		
BY	3 Wildowed 4 Divorced	R OR DATES							Jani, 416.)	Socially: BLACK				
ED	15. DECEDENT'S EDUCA (Specify only highest grade or	18s. DE	100. DECEDENT'S USUAL OCCUPATION					18b. KIND OF BUSINESS/INDUSTR				TON		
LET	Elementary/Secondary (0-12)	life.	(Give kind of work done during most of working life. Do NOT use retired.)											
COMPLETED	1.2 17. FATHER'S NAME (First, Middle, Last)		LABORER					BETHLEHEM STEEL				EL CORP.		
	BUD MILTO	N CAME	ROM				LET		ME (First, Mic			NT.		
) BE	19a. INFORMANT'S NAME (Type/Print)	N CHILL		. MAILING	ADDRESS	(Street e			Route Number		MERO			
5	EDITH SAPPINGTO	N							BALT				21229	
	20a. METHOD OF DISPOSITION  ★ XBuriel 2 ☐ Cremation 3 ☐ Remov	al from State	20b. PLACE A	ND DATE	OF DISPOS	ITION (Na	me of		DATE			City or To		
	TI. SIGNATURE OF FUNERAL SERVICE LICE	usile /	LOUDO	N P	ARK	CEN	(ETE	RY	5/2	BAI	LTIM	ORE	MD.	
	Samolas	11/2.	AT	1.0	š [22.	NAME AN	U ADDRES	S OF FAC	BET'	rs fu	JNER	AL I	HOME	
$\dashv$	21 PART Motor the discourse of an	V Cro	mour	W	<i>)</i> [ ]	129	IV .	CAR	OPTM	E ST	<ul> <li>BA</li> </ul>	LTO	MD21213	
	23. PART I Inter the diseases, or co shock, or heart failure. Li	st only ona caus	e on aach line.	eth. Do i	10t enter	the mod	de Of dyl	ng, auch	n ea cardia	c or reapl	ratory an	reat,	Approximate Interval Between	
	IMMEDIATE CAUSE (Final disease or condition And Conset and D									Onset and Death				
	DUE TO (OR AS A CONSCOUENCE OF):													
NO	disease or condition resulting in death)  Due to (or as a conscouence of):  Sequantielly list conditions, if any, leading to immediate cause. Enter UNDERLYING  Due to (or as a conscouence of):  Due to (or as a conscouence of):  Austral													
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING													
Ĕ	CAUSE (Disease or Injury that initiated eventa	DUE TO (	OR AS A CONSEC	UENCE O	F):									
H	reaulting in death) LAST													
	PART II. Other algorificant conditions contributing to death but not recuiting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY									24b.	WERE AUTOPSY FINDINGS			
DICAL	PERFORMED?  1 VES 2 V NO									AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
ME		3'							_				1 YES 2 NO	
AN	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL	BUTE TO CAL					UNC	ERTAIN	1 🗆					
SICI	EXAMINER?	HOSPITAL:			OTHER	t:		_						
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF I	NJURY	28b. TIM	E OF	28c. INJU	JRY AT	Ildenes (	6 Other (	Specify)	NJURY OC	CURED		
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day	( Year)	URY M	1 Y	RK? ES 2 🗌	NO							
	3 Suicide 8 Could not be	INJURY — At home, ferm, street, factory, offics itc. (Specify)				281. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
COMPLETED	4 Nomicide determined													
MP	29e. CERTIFIER (Check only) one)  2 MEDICAL EXAMINED: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
	29b. SIGNATURE AND TITLE OF CERTIFIER													
290. DATE  ALCLUMES & CLOWN B 28541  30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  LEPUUING 6-CHEM 700 Peaking for Bld. BBG. N.											E SIGNED (Month, Day, Year)			
												3/1/9		
											· M	1) -	ne 30	
	MAY (Moning 9950)	COSTANEGRATA	S SIGNATURE											



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 YEAR VIOLA CLEMONS В. APRIL 27 5: 15 a 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign OCT.10, 1 M 2 X K MONTHS DAYS HOURS 240-07-2608 CAROLINA 78 1916 N. Should Se. FACILITY NAME (If not institution, give street and number OR LOCATION OF DEATH BALTIMORE 9c. COUNTY OF DEATH CARE RUXTON NURSING MANOR HOME DIRECTOR Pages 1, 2, 3 RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY
X LIMITS?
1 YES 2 NO BALTIMORE MARYLAND n/a permit. FUNERAL 10e, STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Nours after death. Page 6 may be retained by the hospital or attending physician.
 Indoor the funeral director, page 5 should be detached for use as the burial-transit 1205 2233 STATES ELDERRY UNITED STREET 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No—II yes, specify Cubert, Mexicen, Puerto Ricen, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 ANO 14. RACE — American Indian, Black, While, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced "BLACK COMPLETED 15. DECEOENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION 18b. KING OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) BALTIMORE CITY ntary/Secondary (0-12) College (1-4 or 5+) 12 TH COOK PUBLIC SCHOOLS 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Surneme)
LAURA ANN WHITAKER **THOMAS** BANKS LAURA 品 notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Numb Number or Rural Route Number, City or Town, State, Zip Code)
DRIVE, RALEIGH, N. CAROLINA 27610 2 ROSE BUNCH KEITH pe 20e WETHOD OF DISPOSITION
1 Deuriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must cemetery, crematory of other CEMETERY 5-95 4 Donation 5 Other (Specify) RALEIGH, N. CAROLINA examiner 21. SIGNATURE OF FUNERAL SERVICE LICES 22, NAME AND ADDRESS OF FACILITY WM, C. MARCH FH.-1101 E. NORTH AVENUE n by the fi medical 23. PART I. Enter the diseases, or complicatione that caused the deeth. Do not enter the mode of dying, such as cardisc or respiratory arrest, shock, or haert failure. Liet only one cause on asch line. filled in by t intervai Between cremation, or IMMEDIATE CAUSE (Finsi Onset and Death the disease or condition_ PANCREAS and completely fi to burial, crematio CARCINOMA resulting in death) Toulhs executed within event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 traumatic CERTIFICATION Sequentially list conditions, prior to DUE TO (OR AS A CONSEQUENCE OF): If sny, issding to immediate cause. Enter UNDERLYING signed by the attending physician a Health and Mental Hygiene prior to HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be CAUSE (Disesse or injury other DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST 6 Injury. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATN? PERFORMED? amy 1 YES 2 NO shows a 1 YES 2 NO t, of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DUNCERTAIN PHYSICIAN: has be. Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate h HOSPITAL: OTHER:
4 Nursing Name 5 - Residence 8 - Other (Specify) 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 6 the 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Dey, Yeer) 28b. TIME OF marked, 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED this c 1 Natural
2 Accident 5 Pending 1 YES 2 NO BY After death DIRECTOR: Aff hours after de-item 28 is n 3 Sulcide 28e. PLACE OF INJURY — At home, Jerm, street, Jactory, office building, etc. (Specify) 28I. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECT DE filed within 72 hours at IMPORTANT: If Item 2 29e. CERTIFIER 1 MCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the ceuse(s) end menner ea stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 2 PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) SHILADI, MD. OSLER



3. TIME OF DEATH

10d. INSIDE CITY

1 YES 2 NO

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Approximets Interval Batween

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?

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Home, Inc

Onsat and Death

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2. DATE OF DEATH

EMPLÉ 104 APRI 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH
(Month, Day, Year)
May 12, 192 5. SEX 6. AGE (In yrs. lest birthdey) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign 224-24-140 69 1 5 M 2 | F DAYS HOURS YRS. Virginia Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Harbon N/A OSPI tal TIMORE RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Mary land IMORE permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? ephe funeral director, page 5 should be detached for use as the burial-transit rive 21225 Unit hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, OIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yee or No—
If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) Manufacturina -Ineworker once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme, notified at uncan BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number of Rural Route 2 phle 010 å 20a. METHOD OF DISPOSITION
1 ☐ Burlel 2 戊 Cremation 3 ☐ Removal from State
4 ☐ Donation 6 ☐ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of must rematory nc. 22. NAME AND ADDRESS OF FACILITY AMONOSE 21. SIGNATURE OF FUNERAL SERVICE LICENSE Sulphur Spring Rd, Arbutus, MD 2427 filled in by the cremation, or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final DUE TO (OR AS A CONSEQUENCE OF): or other traumatic event, the disease or condition completely reaulting in death) HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with DIVISION OF VITAL RECORDS, P.O. BOX 68760 prior to burial, CERTIFICATION signed by the attending physician and Health and Mental Hygiene prior to bur Sequentially list conditions, If any, issding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury arterio selastro Cardrolacido DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST MEDICAL PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? any 1 - YES 2 70 NO 23 shows certificate has been 6 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 YES 2 NO 1 | Inputiant 2 | ER/Outputient 3 | DOA 6 #e DIRECTOR: After this cert hours after death with the litem 28 is marked, o 27. MANNER OF DEATH 26a. DATE OF INJURY 28b. TIME OF 26c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 1 YES BY 2 NO Investigation 2 Accident 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 26s. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 8 Could not be COMPLETED 4 Homicide If Item 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my kno TO THE FUNERAL D
TO THE FUNERAL D
DE filed within 72 h
IMPORTANT: If Its wiedge, death occurred at the time, date end place, end due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the 29b. SIONATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 207809 Davilzo 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3721 Poles St. Balz. Med 2122

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

**CERTIFICATE OF DEATH** 

FOR STATE REGISTRAR

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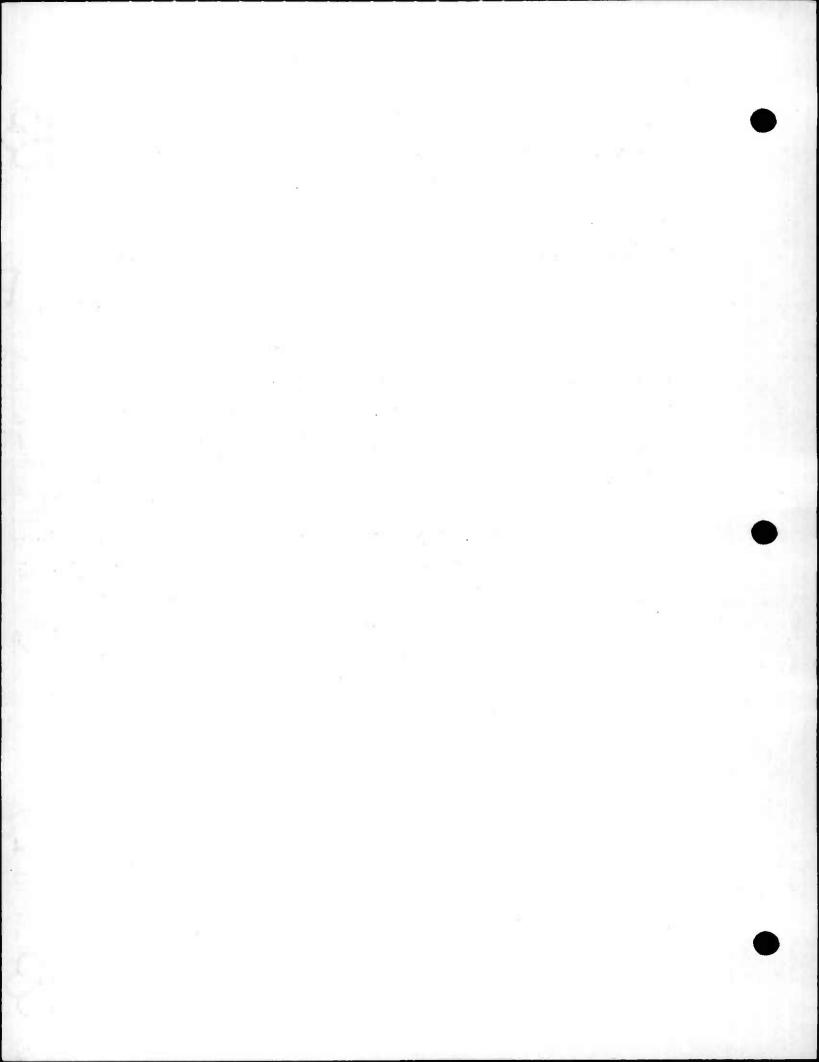
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1. DECEDENT'S NAME (First, Middle, Last)

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	ĺ
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		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTMEN CERTIFICAT	T OF HEALTH AND E OF DEATH	MENTA	L HYGIENE REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)	FETER	VERNON CLASH CH	retrn	MONT		YEAR	3. TIME OF DEATH	
		4. SOCIAL SECURITY NUMBER			R 1 YEAR IF UNDER 24 HRS.	7. DATE	OF BIRTH	8. BIRTH	IPLACE (State or Foreign	
pino		220-09-1506  9e. FACILITY NAME (If not institution, give str	1 M 2 □ F S	2 YRS. MONTHS	DAYS HOURS MIN.	DEC	31,191	2 Ma	iryland	
1, 2, 3 should	TOR	NOVTHWEST RESIDENCE OF DECEDENT	Hospital	Center "	Randa	112	un T	-	timore	
Pages	DIRECTOR	10a. STATE 10b. COUNTY	Himne.	10g CITY, TOWN	OR LOCATION 11E	37			10d. INSIDE CITY LIMITS?	
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9 2		15. DECEDENT'S EDUC (Specify only highest grade of		16a. DECEDENT'S USUAL C (Give kind of work done life. Do NOT use retired.)	CCUPATION during most of working	166	nary Car		hipbuildin	
spit c	COMPL	8th grade	0011090 (1-4 01 0 + 7)	WELDER	•	a		ydo		
be det	E CO	17. FATHER'S NAME (First, Middle, Last)	CHESTER	0	18. MOTHER'S N	IAME (First,	Middle, Maiden Surnam	334	-	
should	TO BE	19a, INFORMANT'S NAME (Type/Print)			S (Street and Number or Rura	I Route Num	ber, City or Town, State	, Zig Code)	121208,	
age a	-	20a. METHOD OF DISPOSITION	STER	T905C	FISTOND }	aci	Charles	AKESC	sille ma	
e 6 m rector,		1 Duriel 2 Cremetion 3 Remo		PLACE AND DATE OF DISPO netery, crematory or other place		4/2	W CO	City or To	in Mal	
death. Page e funeral dire I. examiner n		21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE		NAME AND ADDRESS OF F	ACILITY 5	240 RE	15.18	RSTOWN RO	
	11	Herry	Have	- C	HAMMAN	Han	is Fill.	Palti	NOKE NOZE	
in by remedic		23. PART I. Enter the diseases, or co ahock, or heart failure. L	ompfications that caused lat only one cause on a	the death. Do not ante	tha moda of dying, su	ch as can	diac or respiratory	arrest,	Approximata Interval Batween	
Pe light		IMMEDIATE CAUSE (Final disease or condition PNEUNONIA FIVE O								
completely ial, cremat event,		resulting in death)		CONSEQUENCE OF):					I TO OA	
and o bur	NO NO	Sequentially list conditions, b	DUE TO (OR AS A	CONSEQUENCE OF):						
	CAT	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury								
certiing Hygie	CERTIFICATION	that initiated events resulting in death) LAST								
Me		PART II. Other aignificant conditions	contributing to death be	ut not resulting in the u	ndariving cause given in	n Part I.	24s. WAS AN AUTOP	SY 24h	. WERE AUTOPSY FINDINGS	
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w requires that been signed pt. of Health a shows any	ME		G, DE						1 TES 2 NO	
2 6 5 G	IAN	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH (Check		IN 🔲				
SICIAN: The lar certificate has the State Deg	PHYSICIAN:	EXAMINER?  1 YES 2 NO	HOSPITAL: 1 Impatient 2 ER/Outp	entient 3 DOA 4 Nu	R: sing Home 5 - Residence	6 🗆 Othe	r (Specify)			
this with		27. MANNER OF DEATH  1 Netural 5 Pending	280. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DES	SCRIBE HOW INJURY	OCCURED		
NDING I I: After r death is man	D BY	2 Accident Investigation 3 Suicide 8 Could not be		- At home, larm, street, fac	1 YES 2 NO	28f. LOC	ATION (Street and Num	nber or Rural R	loute Number,	
OR ATTENDING DIRECTOR: After hours after death item 28 is ma	ETE	4 Homicide determined	outsid, etc. jopes			N	or Town, State)			
N N N	COMPLETED		IAN: To the best of my knowl : On the basis of examination						) and manner as stated.	
TO THE HOSPI TO THE FUNER Be filed within	BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	200		29c, LICENSE NU			DATE SIGNED	(Month, Day, Year)	
T C D D D D D D D D D D D D D D D D D D	0	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Torse Drine)	043				24,1995	
3		K.S.RAO.M.D	HOUSE PH	17SICIAN,	LANDALLS	10 W1	HOSPIT	2 6		
		MAY 01 1995	12. REASTRAS'S SIGN	artell						

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3. TIME OF OEATH

10d. INSIDE CITY LIMITS?

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2. DATE OF DEATH

April 27, 1995

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

B.

Campbell

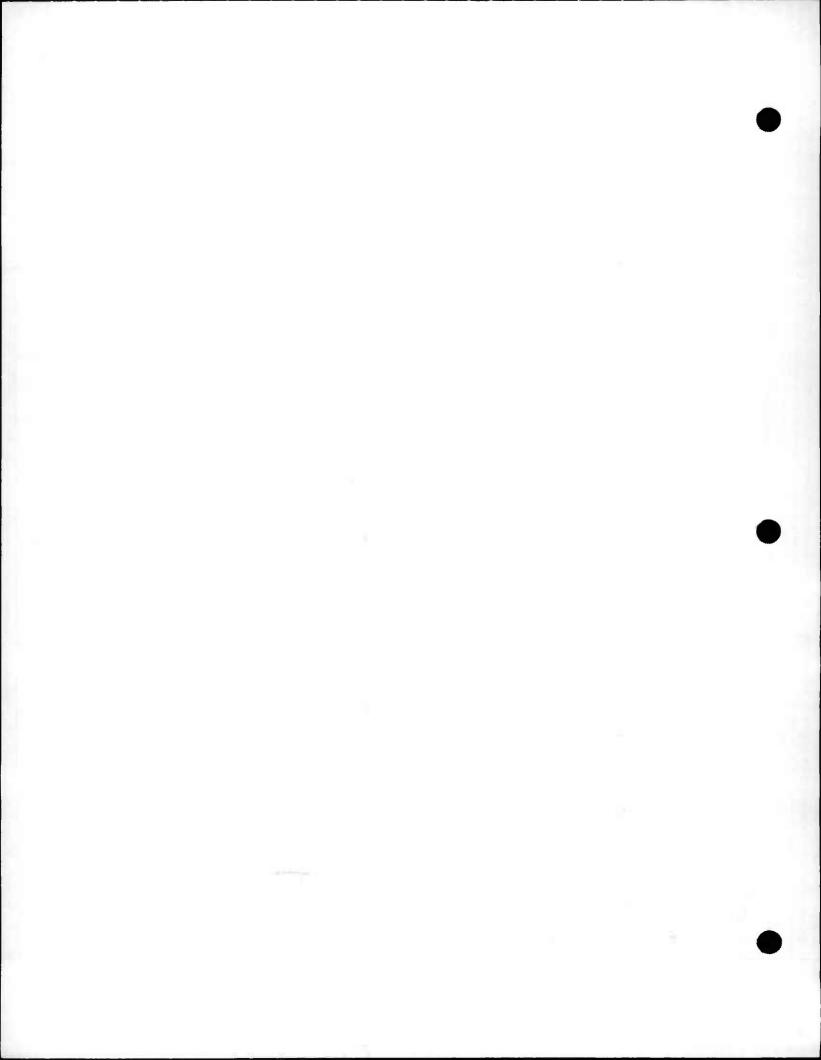
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4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) NOV. 8,1922 5. SEX 6. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 1 - M 2 XF DAYS HOURS 242 30 1638 72 YRS Atlanta, Ga. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR 1010 Cord Street Middle River Baltimore RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Baltimore Middle River permit. FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10a, CITIZEN OF WHAT COUNTRY? page 5 should be detached for use as the burial-transit 1010 Cord Street 21220 U.S.A. retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 THO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuben, Mexican, Puerto Ricen, stc.) BALTIMORE, MARYLAND 21215-0020 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried BY YES 2 NO Specify: Specify: 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) 8 Waitress Restaurant 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sur Lonnie Frank Cooper Jennie Mae Wright Ħ BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Edward J. Campbell 1010 Cord Street Middle River Maryland 21220 hours after death. Page 6 may be 9 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must OATE sysician and completely filled in by the funeral director, prior to burial, cremation, or removal. Burlel 2 Cremation 3 - Re Greenmount Crematory 4 Donation 6 Other (Specify) 4/29/95 Baltimore City, Maryland 21. SIGNATURE OF FUNERALISMENVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY
Bruzdzinski Funeral Home P.A. 1407 Eastern Ave Baltimore, Maryland 21221 the medical 23. PART I timter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition End Stage lung caucer
DUE TO (OR AS A CONSEQUENCE OF): event, resulting in death) traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate the attending physician I Mental Hygiene prior to death certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 0 Injury. PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE been signed by th pt. of Health and IV 24a. WAS AN AUTOPSY any 1 TYES 2 NO OF DEATH? shows 1 - YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has be Dept. 23 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL OR ATTENDING PHYSICIAN: The I After this certificate death with the State HOSPITAL: OTHER: 1 YES 2 100 Inpetient 2 - ER/Outpetient 3 - DOA 4 - Nursing Home 5 Residence 6 - Other (Specify) 0 27. MANNER OF OEATH 28e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT 26d. OESCRIBE HOW INJURY OCCURED marked, 1 Hatural 5 Pending м 1 YES 2 NO BY Accident 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) .00 DIRECTOR: A 6 Could not be ETED 28 4 Homicide determined item COMPL 1 PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end manner ee stated. (Check only one) TO THE HOSPITAL
TO THE FUNERAL I
Be filed within 72 h
IMPORTANT: If II 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner ea stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE enermo 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Street Balt MD21201 120 S. Greene 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

OHMH-18 Rev 1/89



phode

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760 THE HOSPITAL D THE FUNERAL DI fled within 72 ho TO THE HOSPITAL
TO THE FUNERAL I
BE filed within 72 h
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L DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	DIRECTOR; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 is hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	Hem 28 is marked as Hem 23 shaws any interes or other transmissions are the marked assembles assembled as and the
ENDING P	OR: After the	the mark
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CERTIFICATION

BY

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29b. SIGNATURE AND TITLE OF CERTIFIER

DAVID

95 13129 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR MARIE DOZIER APRIL 1995 28, 5:12 P 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 11-21-21 6. AGE (In yrs. last birthday, IF UNDER 24 HRS. IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign Country) 215-24-4535 DAYS HOURS Š.C. 1 M 2X XF 73 YRS. 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY. TOWN OR LOCATION OF DEATH Sc. COUNTY OF GEATH DIRECTOR N/A 4034 HILLEN RD. BALTIMORE 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD N/A BALTIMORE CITY 1)(YES 2 | NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4034 HILLEN ROAD 21218 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Noif yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married 87 1 TES 2X NO Specify: **X** X Widowed 4 ☐ Divorced BLACK COMPLETED 15. DECEOENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INOUSTRY (Specify only hig Elementary/Secondary (0-12) College (1-4 or 5+) PRESSER 12 COAT FACTORY N/A 17. FATHER'S NAME (First Middle Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN BERTHA **BE** PERRY 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MERTIERAN DOZIER 4034 HILLEN ROAD BALTIMORE, MD. 21218 20s. METHOD OF DISPOSITION 20b. PLACE AND OATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE 1 Donation 8 Other (Specify) BALTIMORE CEMETERY 5/4 BALTIMORE, MD. 21. SIGNALIME OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY BETTS FUNERAL HOME 1129 N. CAROLINE ST. BALTO., MD.21213 23. PART Uniter the disesses, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, shock, or heart failure. List only one cause on each line. Interval Batween IMMEDIATE CAUSE (Final Onset and Death disesse or condition Arteriosclerotic Cardiovascular Disease resulting in desth) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if sny, isading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initisted events reaulting in death) LAST PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO **DF DEATH?** 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 Department 2 ER/Outpatient 3 DOA 4 - Nursing Home 5X Residence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident 5 Pending Investigation 1 YES 2 NO 28s. PLACE OF INJURY — Al home, farm, street, factory, office building, atc. (Specify) 3 Sulcide 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide determined 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and due to the ceuse(a) and menner as stated. 2 MEDICAL EXAMINER: On the besis of ex etion and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated.

29c. LICENSE NUMBER

OCME

111 Penn Street, Baltimore, Maryland 21201

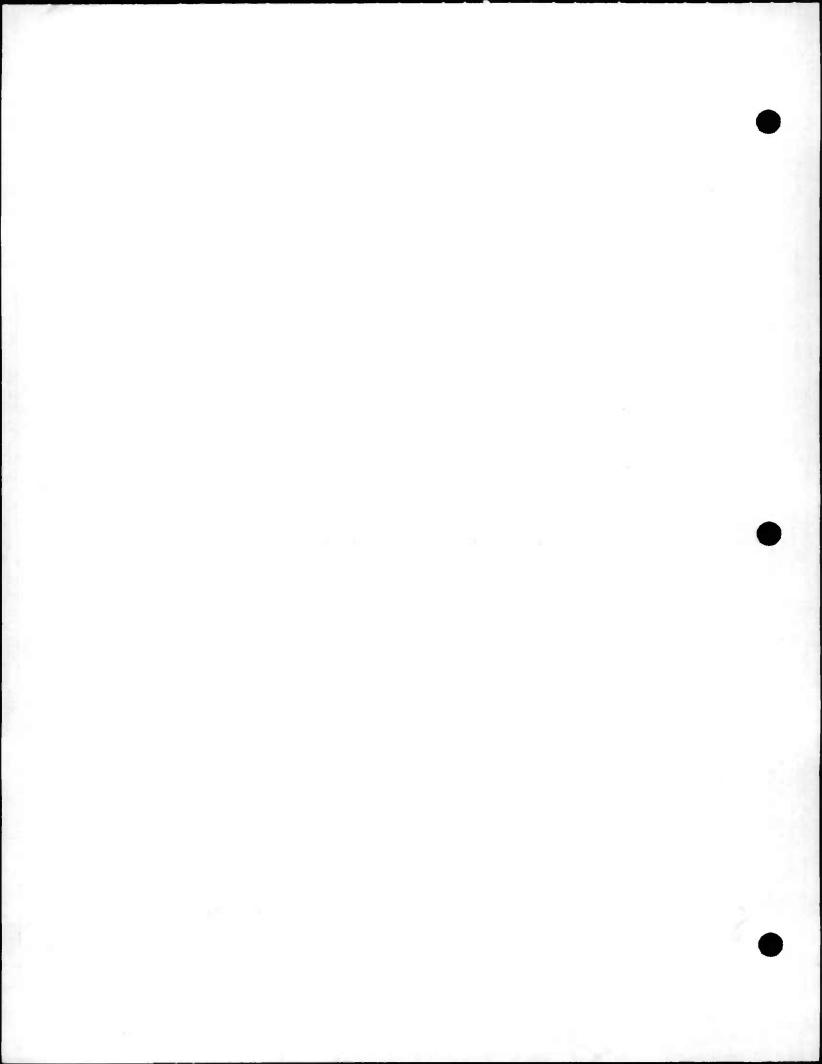
32. REGISTRAR'S SIGNATURE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

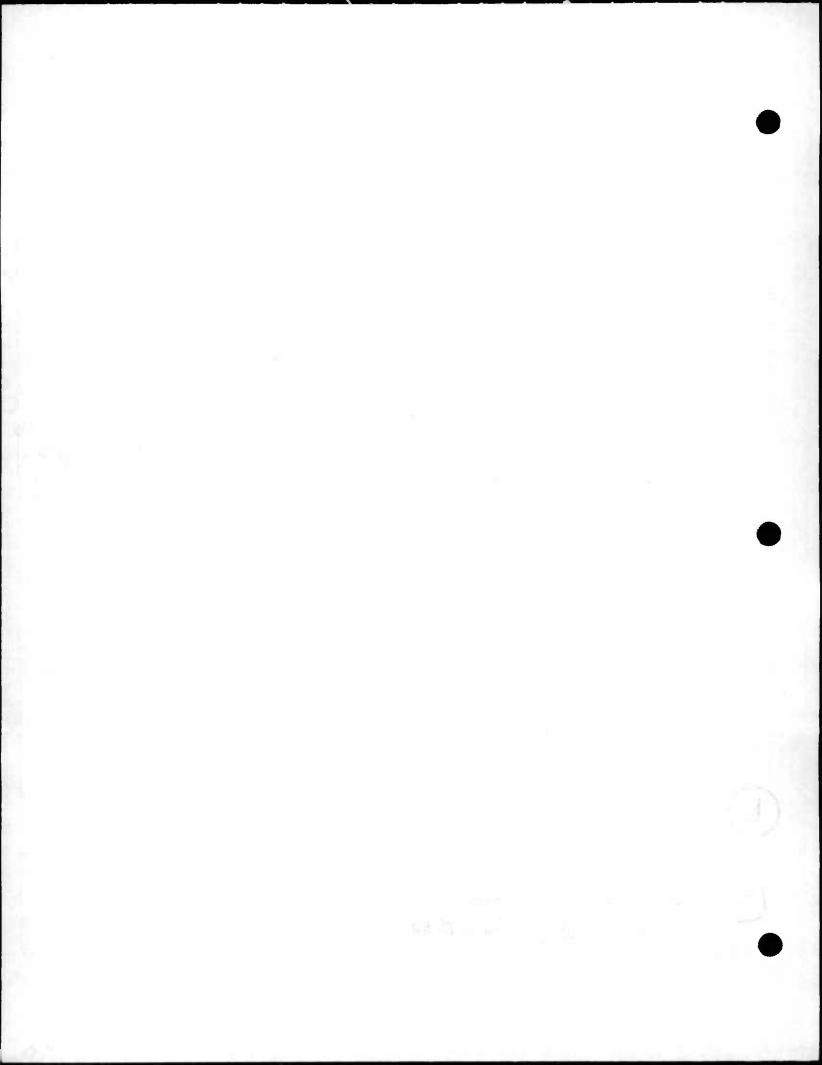
FOWLER M.D.

29d. DATE SIGNED (Month, Day, Year)

APRIL 29,1995



		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR CERTIF	TMENT OF	HEALTH AND	MENTAL HYGIEN		
		1. OECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF OEATH
		Catherine Ann I					April 28.		8:00a M
Pin		213-07-7591	1 M 2 K F 95	n yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Morth, Day, Year)	00 K	ATTHPLACE (State or Foreign buntry) [arvland
, 2, 3 should	DIRECTOR	99. FACILITY NAME (If not institution, give s  14 E. Elm Avenu RESIDENCE OF DECEDENT	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s		Balt:	on location of d imore	EATH	Balti	
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BALTIMORE, MARYLAND after death. Page 6 may be retained by the hospit by the funeral director, page 5 should be detached noval. cal examiner must be notified at once.		≥1. SIGNATURE OF FUNERAL SERVICES LICE  Martin	Depeth			Belair H	The Dip		neral Home Inc aryland 21206
OX 68760  B be executed within the hours after sician and completely filled in by the rich to burial, cremation, or removal traumatic event, the medical is	NOI	23. PART I. Enter the diseasea, or cahock, or heart failure. I IMMEDIATE CAUSE (Finel disease or condition reaulting in death)  Sequentielly list conditions, if any, leading to immediate	DUE TO (OR AS A OUE TO (OR AS A A	CONSEQUENCE OF	en d		Cess.	Tatory arrest,	Approximata interval Batween Onset and Death
S, P.O. BO) death certificate be attending physician ental Hygiene prior iny, or other trau	CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	CDUE TO (OR AS A CONSEQUENCE OF):						
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OF VITA PHYSICIAN: The this certificate h with the State E read, or item	HYS	27. MANNER OF DEATH	1 ☐ Inpetient 2 ☐ ER/Outpe	26b. TIME	OF 26c. IN.	JURY AT	6 Other (Specify)  28d, DESCRIBE HOW II	NJURY OCCURED	
NG PH First Ph H Market	BY	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU	M 1 🗆	ORK? YES 2 NO			
		3 Suicide 6 Could not be determined	28s. PLACE OF INJURY - building, atc. (Specif	— At home, ferm, si	reel, factory, offic	28	261, LOCATION (Street a City or Town, State)	nd Number or Run	al Floute Number,
	COMPLETED		CIAN: To the best of my knowle						e(a) and manner as stated.
TO THE HOSP TO THE FUNE De filed wether IMPORTANT	H	296. SIGNATURE AND TITLE OF CENTIFIER	the.	20		29c. LICENSE NUN	MBER (28)	29d. DATE SIGN	(Month, Day, Year)
1>	5	DR. MICHAEL HY	COMPLETED CAUSE OF DEAT	TH (ITEM 27) (Type,	Print)		-	1/9	-1/10.
		31. DATE FILED (MORTH), Day, YORK 1995	JE REGISTRAN'S SIGNA	artall					



1. OECEDENT'S NAME (First, Middle, Last)

FOR STATE REGISTRAR

YFAR

Mexico 9c. COUNTY OF DEATH N.A.

10g. CITIZEN OF WHAT COUNTRY? U.S.A.

3. TIME OF DEATH

10d. INSIDE CITY 1 X YES 2 | NO

14. RACE — American Indian, Black, Whita, atc. Specify: White

2210 8. BIRTHPLACE (State or Foreign Country)

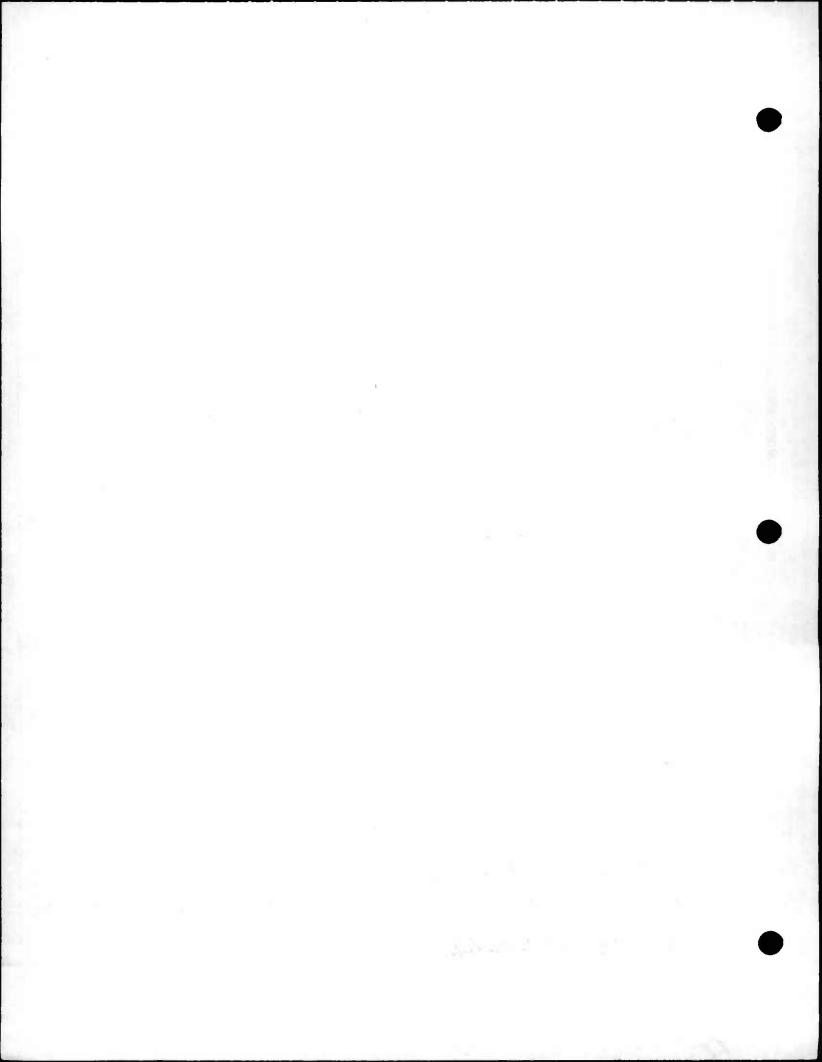
2. DATE OF DEATH MONTH DAY

DO ROY 6976A DIVISION OF VITAL BECORDS

		Jose H	Rober	to	Duar	te					3	41 0	2 19	YEAR
		4. SOCIAL SECURITY NUMBE	R	5. SEX		rs. lest birthday)	IF UNDE	R 1 YEAR	IF UNDER	24 HRS.	7. DATE OF	BIRTH		8. BIR
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the hospital or attending physician.  detached for use as the burial-transit  once.	ED B	15. DECEI	DENT'S EDU	CATION	16	e. DECEDENT'S	USUAL C	CCUPATIO	ON .		Mexi		SINESS/INC	VATSU
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hours after death. Page 6 may be rets bed in by the funeral director, page 5 st or removal. medical examiner must be not	De notifie	Janice Dua				3454	A 6t	h St	reet		Baltir	more,	Mary	y1ar
	must	20a, METHOD OF DISPOSITIO  1 2 Burlal 2 Cremation 4 Donation 5 Other (S	3 🗆 Reme	oval from Stata	cemeter	ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE OF ACE AND DATE O	ther place!	1		ark	4/26		cation – en Bu	
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223	를 입	30. NAME AND ADDRESS OF F	PERSON WHO	COMPLETED CAU	SE OF DEATH	(ITEM 27) (Type.	Print)		0.0	C.M.	E.		A	ori.
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	1 1	31. DATE FILED (Month, Day, Ye	ar)	32. REGISTRA	R'S SIGNATU	111 P	G1111	SLI	eet	Be	TTTIII	ore,	Md)	LAT

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

> tronic Technology len Surname) cevedo lown, State, Zip Code) , Maryland 21225 LOCATION - City or Town, State len Burnie, Maryland 1 Home P.A. timore, Md. 21225 piratory arrest, Approximeta intervai Batween Onset and Daeth elas AN AUTOPSY ORMED? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 2 - NO TYES 2 NO V INJURY OCCURED et and Number or Rural Route Number, and due to the cause(a) end manner as stated. 29d. DATE SIGNED (Month, Day, Year) April 23 1995 11 Penn Street, Baltimore, Maryland 21201 DHMH-18 Rev 1/89



		1 - FOR STATE OF MARYLAND / DEPAREGISTRAR CERTIFICATION CONTRACTOR CERTIFICATION CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRACTOR CONTRAC	RTMENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.							
	2034	1. DECEDENT'S NAME (First, Middle, Last)  4. SOCIAL SECURITY NUMBER  5. SEX  6. AGE (In was last higheren	PMAN	2. DATE OF OEATH DAY	year 3. TIME OF DEATH 4:15 am						
		4. SOCIAL SECURITY NUMBER  2.16-20-2927  3. SEX  6. AGE (In yrs. last birthday)  1 □ M 2 □ F 67  4. SOCIAL SECURITY NUMBER  7. SEX  6. AGE (In yrs. last birthday)	FUNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)						
3 should	æ	9a. FACILITY NAME (If not institution, give alreet and number)	96. CITY, TOWN OR LOCATION OF DE		COUNTY OF DEATH						
6	DIRECTOR	Saint Joseph Medical Center RESIDENCE OF DECEDENT  10s. STATE  10b. COUNTY  10c. C	Towson, Maryle	and	Baltimore						
permit, Pages 1,		100.0	TY, TOWN OR LOCATION  1 timore		10d. INSIDE CITY LIMITS? 1 YES 2 NO						
1st	ERAL	3514 Chestnut Avenue	101, ZIP CODE 2121		CITIZEN OF WHAT COUNTRY? U.S.A.						
215-0020 attending physician. ise as the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced  12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPAN If yes, specify Cuban, Mexica 1 YES 2 NO Specify	n, Puerlo Rican, etc.)	Black, White, etc. Specify:						
	LETED	(Specify only highest grade completed) (Give kind of life. Do NOT	S USUAL OCCUPATION  I work done during most of working use retired.)	16b. KIND OF BUSINESS	White						
AND 21 the hospital or detached for u	COMPL	10 Homem 17. FATHER'S NAME (First, Middle, Last)		Own Ho							
3 E E	BE C	Richard E. Portner	Lola	a M. Ward							
	5	Leroy E. Welch, Sr. 19b. MAILIN 319	Apt. A. Limestor	Route Number, City or Town, State ne Valley Dri	ve, Cockeysville						
6 may stor, pa		1 □XBurial 2 □ Cremation 3 □ Removal from State   cemetery, crematory or	other place)		i — City or Town, State						
2 8 € 5		Dulaney Valley Memorial 5/2 Cockeysville, Maryland  22. NAME AND ADDRESS OF FACILITY Burgee—Henss Funeral Home 21211									
		sem Burger Henss	23 PART   Forest Par diseases or completely that caved the details 23 Part   Forest Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Special Part   Speci								
24 hours filled in I tion, or re		ahock, or heart failure. Liet only one ceuse on each line.  Approximate Interval Between Interval Between Onest and Deat  Approximate Interval Between Onest and Deat  Approximate Interval Between Onest and Deat  Approximate Interval Between Onest and Deat  Due to (or as a consequence of):									
P.O. BOX 683  ith certificate be execute tending physician and cc all Hygiene prior to buria or other traumatic	CERTIFICATION	Sequentially ilst conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. CA OF LUNG WITH METASTISS  DUE TO (OR AS A CONSEQUENCE OF):  c.  DUE TO (OR AS A CONSEQUENCE OF):  d.									
at the by the A Inje	¥.	PART il. Other aignificent conditions contributing to death but not reculting	in the underlying cause given in	Part i. 24s. WAS AN AUTOP PERFORMED?	AVAILABLE PRIOR TO						
signed Health	MEDIC			1 D YES 2 NO	COMPLETION OF CAUSE OF DEATH?						
		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH Y 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DE.	ES NO UNCERTAIN	1 K							
ICIAN: The sertificate h the State or Item	PHYSICIAN:	EXAMINER?  1 VES 2 NO  1 Inpetient 2 ER/Outpetlant 3 DOA	OTHER: 4 □ Nursing Home 5 □ Residence	8 Other (Specify)							
PHYSIC this ce with the did.	ВУ РН	2/ Accident Investigation	M 1 YES 2 NO	28d. DESCRIBE HOW INJURY	OCCURED						
OR ATTENDING OR ATTENDING DIRECTOR: After nours after death Item 28 is ma	ETED	3 Suicide 8 Could not be 4 Homicide 8 Could not be determined 28a. PLACE OF INJURY — At home, farm, building, etc. (Specify)	street, factory, office	281. LOCATION (Street and Num City or Town, State)	iber or Rural Route Number,						
14 72 F	COMPLE	29a. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occur one)  2 MEDICAL EXAMINER: On the best of axamination and/or investigation.									
TO THE HOSPI TO THE FUNEF De filed within IMPORTANT:	TO BE	296. SIGNATURE AND TITLE OF DETRIFIER  30. NAME AND JOORESS OF PERSON WHO COMPLETED CROSS OF DEATH (ITEM 27) (Typ	29c. LICENSE NUM D15824	18ER 29d. 1	DATE SIGNED (Month, Qay, Year)						
$\wedge$		LOPE T VILLA JR MD 7620 YORK RD., TO	and the second second second								
+		MAY 01 1995									

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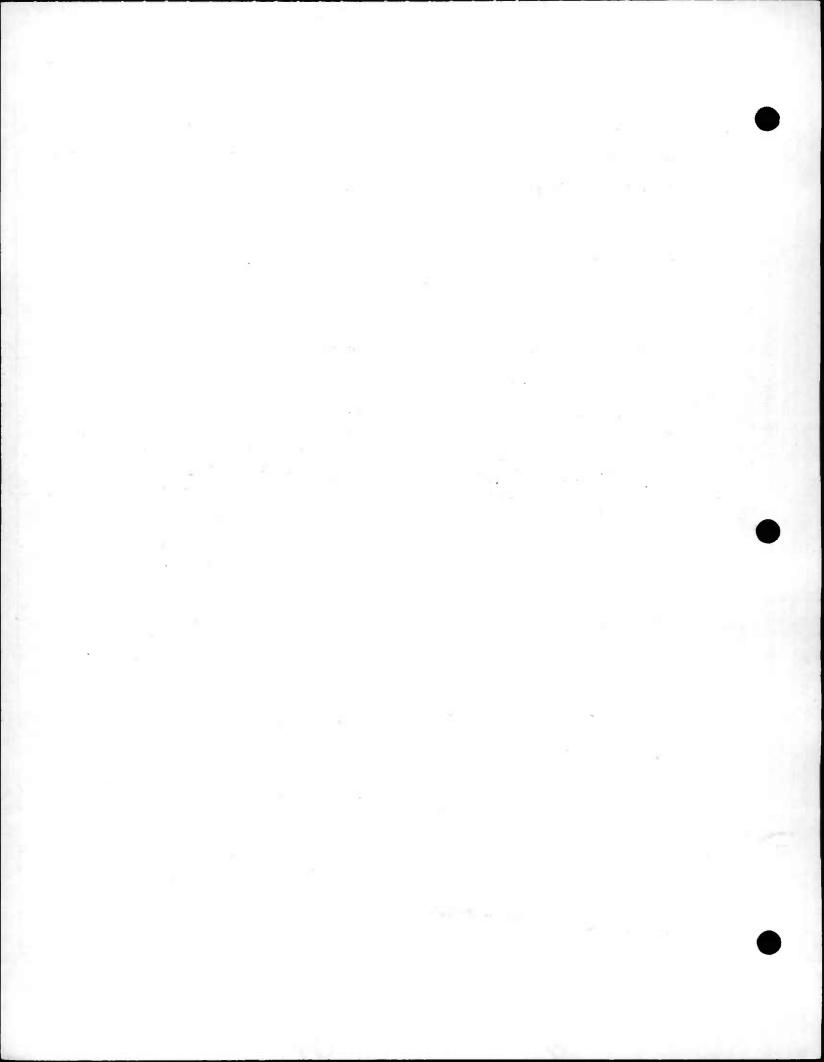
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FELLAT TITAS DE ET BETCA BY - WOYOU CAL

BERRY

LOPE T VILLA LA IVO INZUITORK AD ITOMBON, VD 21204

	1 - STATE REGISTRAR		CERTIFIC	ATE OF	DEATH	REG. NO.				
	1. OECEDENT'S NAME (First, Middle, Las				2. 1	DATE OF DEATH DAY	YEAR	TIME OF OEATH		
	4. SOCIAL SECURITY NUMBER 229-03-9467	5. SEX 6. AG		UNDER 1 YEAR	IF UNDER 24 HRS. 7. E	4 28 MATE OF BIRTH Month, Day, Year) 3-18-01	8. BIRTHPLAC Country)	230P CE (State or Foreign VA.		
OR	9a. FACILITY NAME (If not institution, give		98		R LOCATION OF DEATH	9c. C	OUNTY OF DEATH			
ECTO	10e. STATE 10b. COUN		10c, CITY, T	OWN OR LOCATI				. INSIDE CITY		
DIR	MD. N	A	В	altimo	ore			LIMITS?		
FUNERAL	10e. STREET AND NUMBER			101.	ZIP CODE	10g. (	CITIZEN OF WHAT	COUNTRY?		
JNE	619 N. Mount	12. WAS DECEDENT EVER	DIM II C. ADMED	Las una pro-	21217		USA			
BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YE	S 2 NO	If yes, spe	endent of Hispanic Olecity Cuben, Maxican, Pu 2 MO Specify:	RIGIN? (Specify Yes or No- arlo Rican, etc.)	Specify:			
TED	15. DECEDENT'S ED (Specify only highest gra-	UCATION de completed)	16a. DECEDENT'S USI (Give kind of work	done during mos	N t of working	16b. KIND OF BUSINESS	I BLA	Ch_		
PLET	Elementary/Secondary (0-12) 4th	College (1-4 or 5+) NA	life. Do NOT use re			27.7				
COMPL	17. FATHER'S NAME (First, Middle, Lest)	IVA	Поше	Makeı		N Z irst, Middle, Meiden Surnem				
BEC	T	nomas	Carter		Marga	ret Cart	er			
2	19a. INFORMANT'S NAME (Type/Print)					Number, City or Town, State,				
	Mary E. Gray	1.				timore, MI				
	FD Burial 2 Cremation 3 Ra 4 Donation 5 Other (Specify)	movel from State	ob. PLACE AND DATE OF D emetery, crematory or other Arbutus C	place)		95 Baltin	- City or Town, \$			
	21. SIGNATURE OF FUNERAL SERVICE I			22. NAME AN	D ADDRESS OF FACILITY	1	iore, Mr	•		
	Albert P. Wylie F/H PA 638N.Gilmor ST. 21217									
	23. PART I. Enter the diseases, of shock, or heart failure iMMEDIATE CAUSE (Finel disease or condition resulting in death)	. LIELUTTY ONE COURS ON	each line					Approximata interval Batwe Onset and Des		
CATION	Sequentially list conditions, if any, leading to immediate	b. DUE TO (OR AS	typerfense of:	hine	Carcli	versecula Rese	rase,			
CERTIFIC/	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	c	A CONSEQUENCE OF):							
EDICAL C	PART II. Other aignificent condition	one contributing to death	but not reaulting in ti	he undariying	cause given in Part	I. 24a. WAS AN AUTOPS PERFORMED? 1 — YES 2 XNO	COM	E AUTOPSY FINDING LABLE PRIOR TO IPLETION OF CAUSE DEATH?		
Σ∥	DID TORACCO LIST COAL	TOIDLITE TO CALLE	0.000				1 🗆	YES 2 NO		
SICIAN:	DID TOBACCO USE CON  25. WAS CASE REFERRED TO MEDICAL	IKIBUTE TO CAUSE	26. PLACE OF DEATH (		UNCERTAIN [	J				
Sic	1 YES 2 NO	HOSPITAL: 1   Inpetient 2   ER/Ou	01	THER:	5 Residence 8 -	Other (Specify)				
F	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year,	y 28b, TIME OI	F 28c. INJU	RY AT 28d.	DESCRIBE HOW INJURY	OCCURED			
D BY	2   Accident   Suicide   S   Could not be   Could not be   28s. PLACE OF INJURY — At home, farm, street, factory, office   28s. LOCATION (Street and Number or Rural Route Number, building, etc. (Specify)   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could not be   Could no						Number,			
COMPLETE	4 Homicide determined  29a. CERTIFIER (Check only 1 CERTIFYING PHY	SICIAN: To the best of my kno	wledge, death occurred at	t the time, data a			stated.			
∑ II	one) 2 MEDICAL EXAMIN	IER: On the basis of axaminat	ion and/or investigation, in	my opinion, de	ath occured at the time,	data and place, and due to	the cause(a) and	menner as stated.		
Я П	29b. SIGNATURE AND TITLE OF CERTIFI	ER	0.	/	29c. LICENSE NUMBER	29d. D	ATE SIGNED (Mon	th, Day, Year)		
H	Lecli	in X.		cho.	028541		5/1/9			
	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF E	DEATH (ITEM 27) (Time Prin	w)		3/rd · B	571/9	0		



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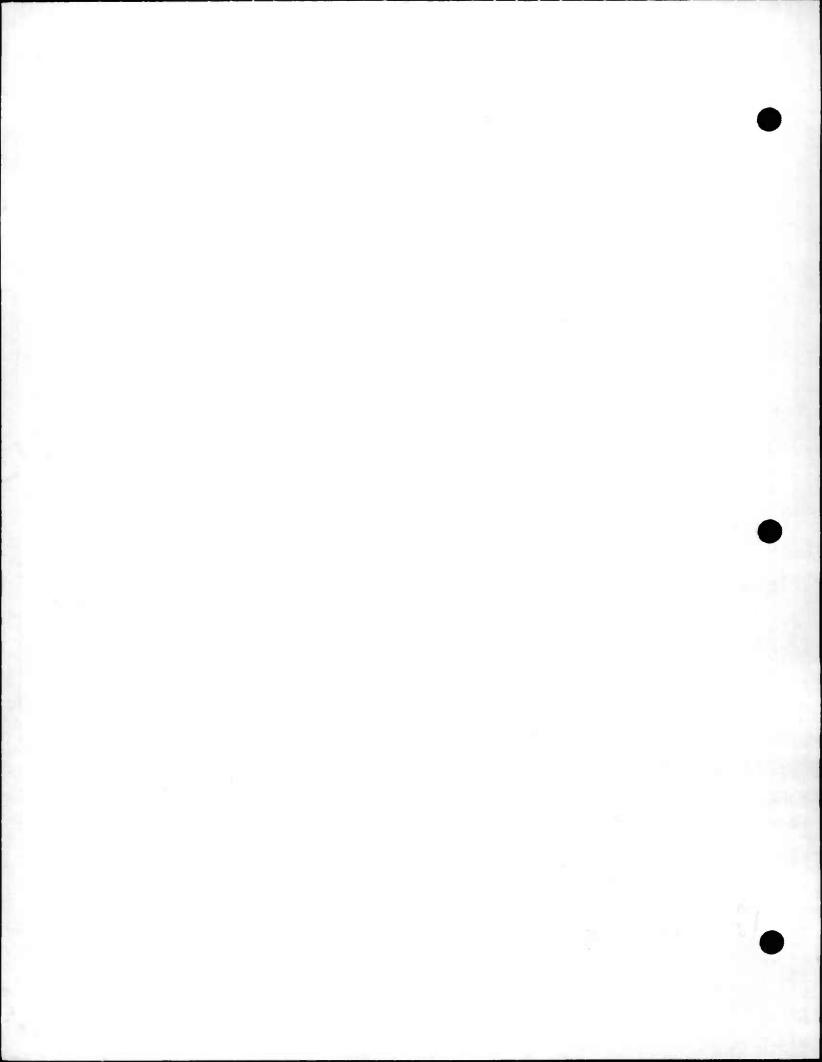
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FOR STATE REGISTRAR

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1. OECEDENT'S NAME (First, Middle, Last) 2. OATE OF DEATH 3. TIME OF DEATH :450 MARIE APRIL REENHILL 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 5. SEX 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign OCT. 25, 1924 219-20-5478 1 M 2 X K 70 DAYS · CAROLINA N. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH Sc. COUNTY OF DEATH DIRECTOR CHURCH HOME HOSPITAL BALTIMORE CITY n/a RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYI AND n/a BALTIMORE YES 2 NO use as the burial-transit permit. FUNERAL 10a, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 201 Ν. WASHINGTON STREET APT.510 21231 UNITED STATES A hours after death. Page 6 may be retained by the hospital or attending physician. filled in by the funeral director, page 5 should be detached for use as the burial-transilion, or removal. 11 MADITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried If yes, specify Cubs
1 YES 2 \\ NO IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced Specify: Specify: BLACK COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. OECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INQUISTRY (Give kind of work done life. Do NOT use retired.) nentery/Secondary (0-12) College (1-4 or 5+) DOMESTIC in own home once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) ROBERT DAUGHTRY ROSA PURVIS BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 9 DOROTHY BARBER 512 CHATEAU AVENUE, BALTIMORE, MARYLAND 21212 pe 20a. METHOD OF DISPOSITION
↑ Burlal 2 □ Cremetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State must °GARRTSON° FOREST VA OWINGS MILLS, MD 4 Donation 5 Other (Specify) medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Beman WM. C. MARCH FH.-1101 Ε. NORTH **AVENUE** 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between IMMEDIATE CAUSE (Finel **Onset and Death** the cremation, disease or condition SPIRATORY completely other traumatic event, resulting in death) executed with DUE TO (OR AS A CONSEQUENCE OF) burial, POXIC ENCEDITALO CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING physician ACUTE CARDIAC death certificate CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events this certificate has been signed by the attending with the State Dept. of Health and Mental Hygier resulting in death) LAST ISCHEMIC CARDIAZ 33133 PART II. Other aignificent conditions contributing to death but not resulting in the undarlying cause given in Part I. he 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? requires that MBLLITUS shows any 1 TYES 2 70 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D PHYSICIAN: MP 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO Inputient 2 - ER/Outputient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF OEATH 26b. TIME OF INJURY 26c. INJURY AT WORK? 28e. DATE OF INJURY marked, 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending DIRECTOR: After the hours after death v 1 YES 2 NO BY 2 Accident OR ATTENDING 28e. PLACE OF INJURY — At he building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is 3 Suicide 6 Could not be COMPLETED 0 THE HOST...
TO THE FUNERAL DIRECTOR...
To filed within 72 hours after 4 Homicide 29e. CERTIFIER 1 DERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner se stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner as stated. 29d. DATE SIGNED (Month, Day, Year) 296. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE FILED (Month, Day,

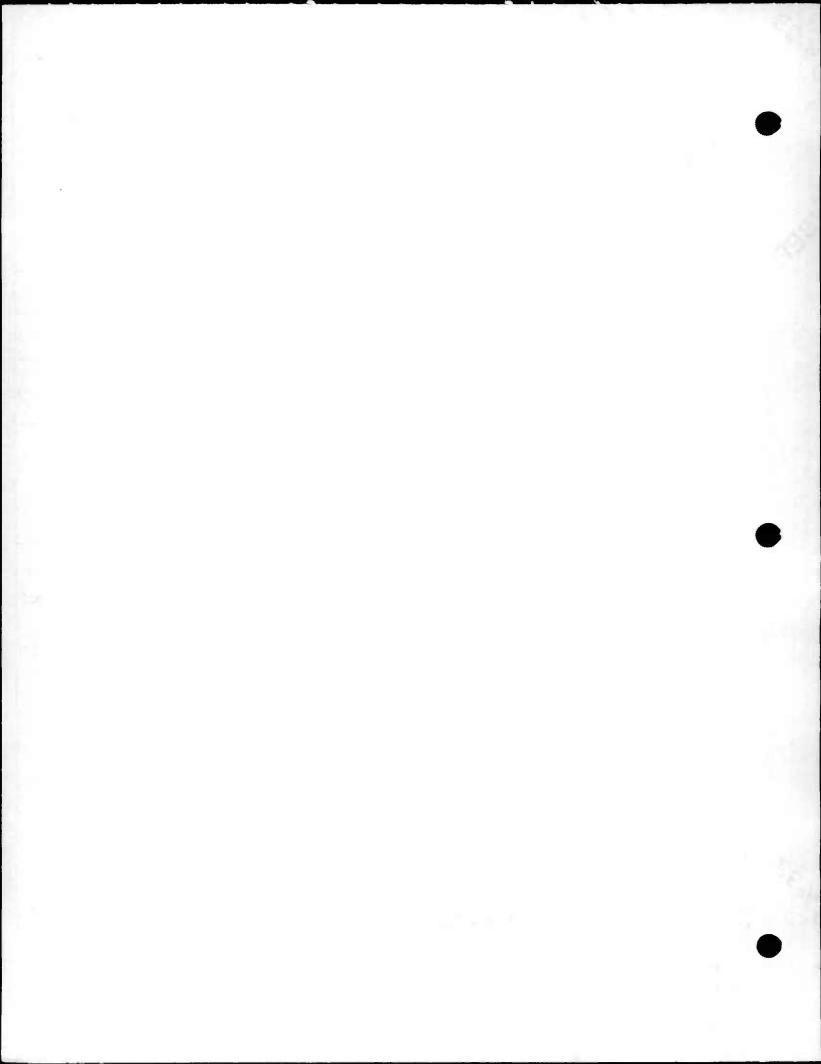
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



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		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC	ENT OF H	HEALTH AND N	MENTAL HYGIEN		
		1. DECEDENT'S NAME (First, Middle, Last)	Louis Thoma	s Geare			2. DATE OF DEATH MONTH April 25,		3. TIME OF DEATH 3:20 A
2, 3 should		4. SOCIAL SECURITY NUMBER 220–20–4804	1 💢 M 2 🗆 F		UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH	a. BIRT	HPLACE (State or Foreign
	OR	90. FACILITY NAME (If not institution, give Union Memorial H	ospital	96		imore	ATH	9c. COUNTY OF Balto.	
r. Pages 1,	DIRECTOR	10s. STATE 10b. COUNT Maryland B	alto. City	10c. CITY, TO	Balt	imore		-	10d. INSIDE CITY LIMITS? VX YES 2 \( \text{NO}\) NO
nsit permit.	FUNERAL	100. STREET AND NUMBER 3712	Chestnut Ave	nue	101	7. ZIP COOE 2	1211	10g. CITIZEN OF	WHAT COUNTRY?
215-0020 attending physician. use as the burial-transit	B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEOENT EVER I FORCES? 1 X YES IF YES, GIVE WAR OR D	N U.S. ARMED 2 NO PATES	If yes, sp	ENDENT OF HISPANI ecify Cuban, Maxican 2 2 NO Specify:			E — American Indian, ik, White, etc.
- P	PLETED	15. DECEDENT'S EDI (Specify only highest gradi Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	18a. DECEDENT'S USL (Give kind of work life. Do NOT use re-	done during mo tired.)	ON ost of working		siness/industry	nanv
YLA by the be det	E COMPL	17. FATHER'S NAME (First, Middle, Last) Cl	aude Thomas			18. MOTHER'S NAM	ME (First, Middle, Maiden atherine I		
MAR be retained te 5 should	TO B	19a. INFORMANT'S NAME (Type/Print) Mrs. Doris Geare		19b. MAILING AD: 3712 C	hestnu	and Number or Aurei A t Avenue	oute Number, City or Tow Baltimore	n, State, Zip Code) Maryla	nd 21211
ector, p	or venu	20a. METHOD OF DISPOSITION **Experience of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the cont	coval from Stata Cen	o.PLACEAND DATE OF D petery, cremetory or other oreland Me	nlacel			cation - city or T	
ALT death.	CABILLIE	21. SIGNATURE OF FUNERAL SERVICE LI	censee Carpl	nter	Burge		Tuneral Ho ad Baltimo		1211
hours after of the or removal.		· V	complications that ceuse List only one ceuse on e	d the desth. Do not each line.	enter the mo	de of dying, such	aa csrdiac or reapi	retory arreat,	Approximata interval Between
y fill		iMMEDIATE CAUSE (Final disease or condition reaulting in death)	aDUE TO (OR AS A	4MPHO	mA				24 NO
executed and com to burial,	CATION	Sequentially list conditions, it any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE OF:  A CONSEQUENCE OF:  A CONSEQUENCE OF:  A CONSEQUENCE OF:	E HEI	ART TA	FILLRE		12 mos
certificate be ding physiciar tygiene prior	III.	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	c. CORO,	NARY A CONSEQUENCE OF):	ARTE	RY DIS	EASE		10 YEAR
DS, P	L CE	PART II. Other aignificent condition	d.	out not resulting in ti	he underlying	g ceuse given in F			. WERE AUTOPSY FINDINGS
E d at C	일					1	PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
- S S S	AN	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUSE C	OF DEATH YES		UNCERTAIN			
SICIAN: The certificate he the State is the State is or Item	ે! ≿	EXAMINER?  1 YES 2 NO  27. MANNER OF GEATH	HOSPITAL: 1 Inpatient 2 ER/Outs 28a. OATE OF INJURY			e 5 Residence 8	28d. DESCRIBE HOW II	ECU	
	B√	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	M 1 1	PRK?			
OR ATTEND DIRECTOR: #		3 Suicide 6 Could not be 4 Homicide determined	building, stc. (Spec	city)	t, factory, offic		281. LOCATION (Street a City or Town, State)	and Number of Rural	Route Number,
4 12 s	릴		ICIAN: To the best of my know ER: On the basis of examination						n) and manner as stated.
TO THE HOSPITAL TO THE FUNERAL De filed within 72	BEC	29b. SIGNATURE AND TITLE OF CERTIFIE	. 1 //	unch		29c. LICENSE NUMI	- 950	29d. DATE SIGNE	(Month, Day, Year)
F F Z :	일	30. NAME AND ADDRESS OF PERSON WI		ATH (ITEM 27) (Type, Prin	nt)	207		7/0	3/73

X CARMANY M.D. 7505 OSLER DR TOWSON 2/204



DHMH-18 Rev 1/89

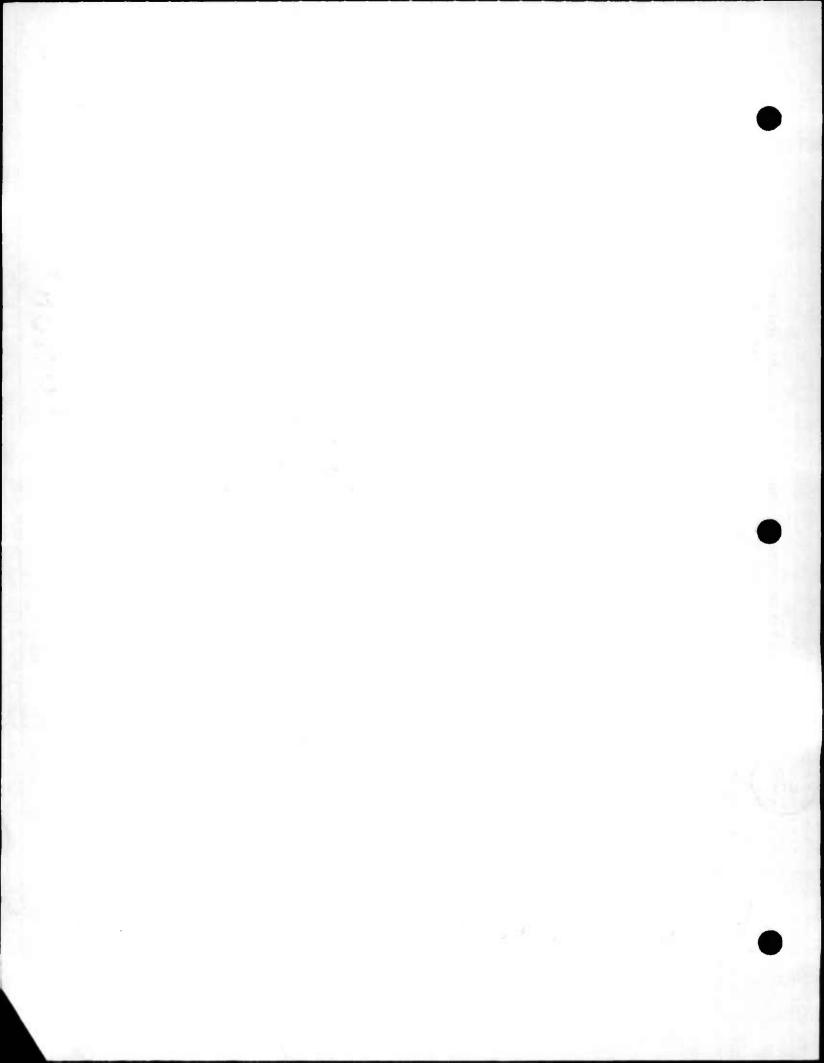
TO THE HOSPITAL OF A SOING BY SIGAN: The law requires that the death certificate be executed with a first feath. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTION When the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 22 hours are the certificate and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It less is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGI	ENE
REGISTRAR	CERTIFICATE OF DEATH REG.	NO.

	1 - STATE REGISTRAR	STATE OF MA		DEPAR ERTIF					MENTAL HYGIE REG. N			
	1. DECEDENT'S NAME (First, Middle, Last,	)	- 0.		IOAII	_ 01	שבת		2. DATE OF DEATH	<u>.                                    </u>		3. TIME OF DEATH
	THEODORE	J. GRI	EY						MONTH 4/25/95	DAY	YEAR	1045A 4
	4. SOCIAL SECURITY NUMBER	5. SEX	AGE (In yrs. les	t birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH		S. BIRTI	IPLACE (State or Foreign
	219 54 9949	1 ∰ M 2 □ F	4 <b>1</b>	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year) 6/11/53		Count	MD.
	9a. FACILITY NAME (If not institution, give	street end number)			9b. CITY	, TOWN C	R LOCATI	ON OF DE		9c. CO	UNTY OF D	
OR	(HOME) 1502 McC	CULLOH ST.				BAT.T	IMOR	E.		RAT	TO.	CTTV
DIRECTOR	RESIDENCE OF DECEDENT									DAL	110.	CIII
IRE	10e. STATE 10b. COUNT			10c. CIT	Y, TOWN							10d. INSIDE CITY LIMITS?
		TO. CITY			BAL'	rimo:						Y☐ YES 2 ☐ NO
FUNERAL	100. STREET AND NUMBER 1502 McCULLOH	т СТ				101	ZIP COD			2.43		WHAT COUNTRY?
JNE	11. MARITAL STATUS	12. WAS DECEDENT	EVEO IN ILE AD	MED	- 40		212				JSA	
ВУ	1 Dever Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 [ IF YES, GIVE WAI	YES 2			If yes, spi	endent control	n, Mexica	IIC ORIGIN? (Specify Y n, Puerto Ricen, etc.)	ee or No-	Spec	E American Indien, k, White, atc. #y: AMERICAN
ED	15. DECEDENT'S ED	UCATION	16a. DE	CEDENT'B	USUAL O	CCUPATIO	N N		16b. KINO OF B	USINESS/II		AMERICAN
ET	(Specify only highest grad	College (1-4 or 5+)	(G life.	ive kind of a Do NOT us	work done se retired.)	during mo:	st of working	90	7 9			
AP.	12	,	S06	IAL	WOR	KER			STATE	OF MI	).	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTI	HER'S NAI	ME (First, Middle, Maide	n Sumama)		
BEC	THEODORE	HARRIS					R	ENTH	A V. GEN	IES		
TO B	19a. INFORMANT'S NAME (Type/Print)		196	b. MAILING	ADDRESS	S (Street e			loute Number, City or To		(ip Code)	
۲	RENTHA ANNE BU	TLER	1	9833	CHE	SLEY	KNO	LL D	R. GAITHE	RSBUR	RG, M	D. 20879
	20a. METHOD OF DISPOSITION 1	novel from State	20b. PLACE			ITION (Na	me of		DATE 20c. L	OCATION -	- City or To	wn, State
	4 ( Donation 5 Other (Specify)		ARBU	TUS ]	PARK	4/2	8/95		AR	BUTUS	s, MD	?
	21. SIGNATURE OF FUNERAL SERVICE L	CENSEE	/				D ADDRES			T HON	(E.D.	Α.
	1/1/1/1/	Col	00						RS FUNERA L. BALTO.			- •
CERTIFICATION	immediate cause (Finel disesse or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events resulting in deeth) LAST	c	R AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A CONSECUTIVE AS A			plune	as	mo	sio	Sys	rde	Onset and Death
PHYSICIAN: MEDICAL	PART II. Other significent condition  Dissemina  DID TOBACCO USE CONT	ted Ko	posi	15	San	COI	na	iven in i	PERFO	PRMED?	246.	MERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
A	25. WAS CASE REFERRED TO MEDICAL	10 040		E OF DEAT			0140	-KIMIN	, ப			
SIC	1 YES 2 NO	HOSPITAL:	R/Outpetient 3	DOA	OTHER	R:	.Va.	oldana i	8 Other (Specify)			
Ě	27. MANNER OF DEATH	28e. DATE OF IN	JURY	28b. TIM	E OF	28c. INJU	JRY AT	siderice	28d. DESCRIBE HOW	INJURY O	CCURED	
ВУ	1 Naturel 5 Pending 2 Accident Investigation	(Month, Day,	1001)	INJ	URY M	1 Y	RK? ES 2	ND				
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF I building, etc	NJURY — At ho	me, ferm, a	treet, fect	ory, office			28f. LOCATION (Street City or Town, Stete	and Number	er or Rural R	loute Number,
COMPLETED		SICIAN: To the best of m										and manner ea stated
BE	296. SIGNATURE AND TITLE OF CEBTIFIE		leso					NSE NUM				(Month, Day, Year)
임	30. NAME AND ADDRESS OF PERSON WA	HO COMPLETED CAUSE	OF DEATH (ITEM		Print) Chas	ze B	rexto	in He	ealth Ser	uri	to in	01 Cathed
	MAY 01 1995	32 BEGISTRAR	SIGNATURE								Ba	or Cathed ermd 21201



the funeral director, page 5 should be detached for use as the burial-transit permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 1014 Back River Neck Road 21221 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuban, Maxican, Puarto Rican, etc.)
1 YES 2 NO Specify: BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 NO 1 Never Married 2 🔀 Married BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) 12 Operating Engineer 17. FATNER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Eugene Franklin Gunter Mary Groom BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mildred B. Gunter 1014 Back River Neck Road Essex, MD 21221 9 20s. METHOD OF DISPOSITION
1 💢 Burlei 2 Cremetton 3 🗆 Removal from State
4 🗆 Donation 5 🗀 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Greensboro Cemetery 4/27/1995 Greensboro, MD. examiner TURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY event, the medical 23. PART L Enter the diseases, of complications that caused the death. Do not enter the mode of dying, such ea cardiac or reepiratory arrest, shock, or heert fellure. List only one cause on each line. filled in by 5 IMMEDIATE CAUSE (Finel disease or condition resulting in desth) and completely fi o burial, cremation . Colon Cancer Approximately 1 Year DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): Alzheimers Dementia traumatic CERTIFICATION Sequentially list conditions. 2 DUE TO (OR AS A CONSEQUENCE OF) signed by the attending physician and Mental Hygiene prior to If any, leading to immediate the death certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II. Other algoriticant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL requires that shows any t. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🖺 UNCERTAIN 🗆 PHYSICIAN: has by Dept. OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate t HOSPITAL: OTHER 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Nome SChandence 6 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF this c. 28c. INJURY AT WORK? marked, 1 X Natural 5 Pending Investigation 1 YES 2 NO After the ВУ 2 Accident 28s. PLACE OF INJURY — At home, larm, atreet, factory, office building, etc. (Specify) 3 Suicide 99 DIRECTOR: / COMPLETED 8 Could not be 4 Homicide 28 detarmined 1 X CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. HOSPITAL (
FUNERAL D
within 72 ho (Check only one) = TO THE HOSPITA
TO THE FUNERAL
DE filed within 72
IMPORTANT: If 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. SIGNATURE AND THE OF CERTIFIER 29c. LICENSE NUMBER BE Kumochlas AD1663 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 20) Type, Print) Rumschlag M.D. 9000 Franklin Square Drive Balt., MD. Martha M. 32. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year)

CERTIFICATE OF DEATH

IF UNDER 1 YEAR

Essex

Essex

10c. CITY, TOWN OR LOCATION

IF UNDER 24 HRS.

HOURS

6. AGE (In vrs. lest birthday

YES

FOR STATE REGISTRAR

Pages 1, 2, 3 should

DIRECTOR

10a. STATE

Maryland

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

222-03-5400

RESIDENCE OF DECEDENT

1995

William Sunday Gunter

1014 Back River Neck Road

Baltimore

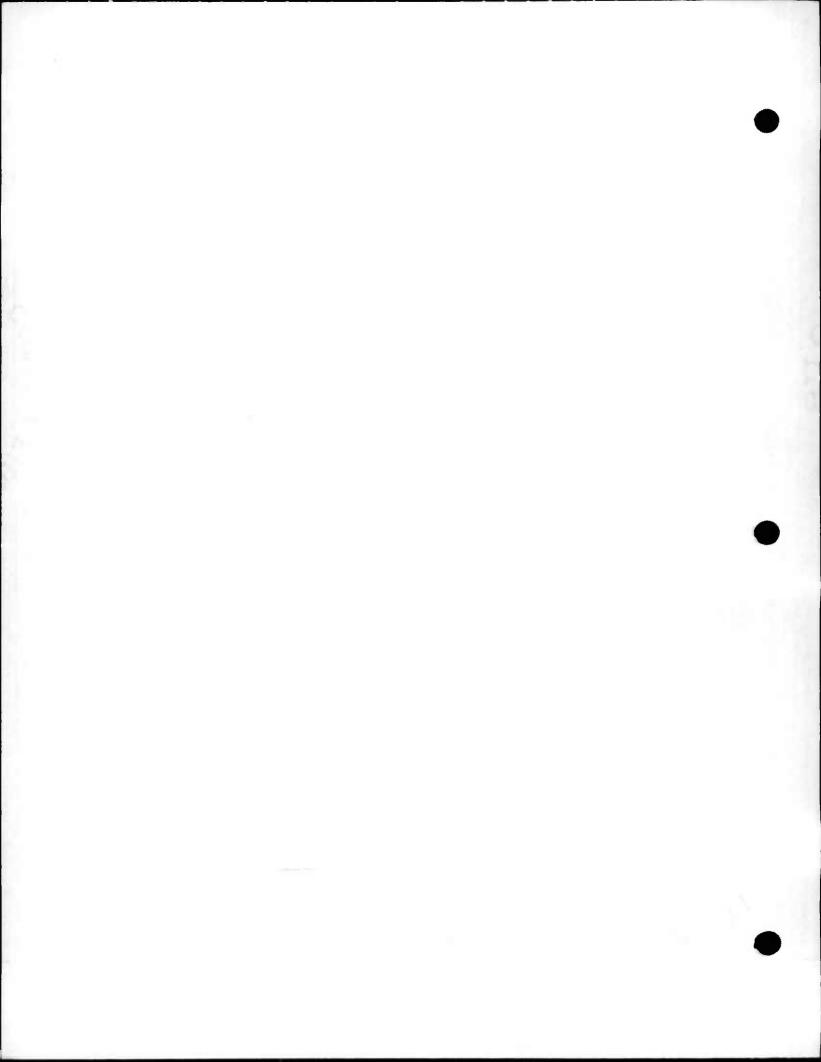
9a. FACILITY NAME (If not institution, give street and number)

5. SEY

1 😿 M 2 🗌 F

95 13137 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO 2. DATE OF DEATH 2:30Pm 1995 April 23 7. DATE OF BIRTN (Month, Day, Year) 8. BIRTNPLACE (State or Foreign Virginia 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Baltimore 10d. INSIDE CITY 1 YES XX NO 10g, CITIZEN OF WHAT COUNTRY? U.S.A. 14. RACE — American Indian, Black, White, atc. Spec#White 16b. KIND OF BUSINESS/INDUSTRY Construction 20c. LOCATION - City or Town, State Bruzdzinski Funeral Home P.A.21221 1407 Old Eastern Ave.Baltimore, MD Approximate Interval Between Onest and Death Year 15 Years 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PERFORMED? 1 TYES 2 NO OF DEATN? 1 YES 2000 28d. DESCRIBE HOW INJURY OCCURED 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) 95

DHMH-16 Ray 1/89



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

295 SIGNATURE AND THEF TH

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CERTIFIE

RESS OF PERSON WHO COMPLETED CAUSE OF DEATH (FORM 27) (Type, Print)

Studies Reduction

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH Mildred Louise Gauss 1995 6:10 April Ρ. 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 212 05 2520 D DAYS HOURS 77 1 M 2 X F May 12, Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Meridian Nursing Center Severna Park Anne Arundel RESIDENCE OF DECEDENT 10b. COUNT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Anne Arundel Pasadena 1 - YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 1933 North Avenue retained by the hospital or attending physician. 5 should be detached for use as the burial-transit 21122 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 TYES 2 NO Specify ВҰ Specify: 3 X Widowed 4 Divorced White 9 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig ᆸ Elamentary/Secondary (0-12) funeral director, page 5 should be detached for College (1-4 or 5+) Home Maker COMPL 8th Own Home 17. FATHER'S NAME (First, Middle, Last) unknown once. 18. MOTHER'S NAME (First, Middle, Malden Surname) Robinson Butler Lena Ħ BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Jennifer Muhl 4320 Mountain Road Pasadena, Maryland 21122 ours after death. Page 6 may be must be 20a. METHOD OF DISPOSITION
1 KBurlel 2 Cremetion 3 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Glen Haven Memorial Park 4/27 Glen Burnie, Maryland 4 Donation 5 Other (Specify) 22. NAME AND ADDRESS OF FACILITY
George J. Gonce Funeral Home P.A. medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES war once 4001 Ritchie Hwy. Baltimore, Md. 21225 completely filled in by the rial, cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ehock, or heert fellure. List only Interval Betw **IMMEDIATE CAUSE (Final** Onset and Death the disease or condition recuiting in death) traumatic event, OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with this certificate has been signed by the attending physician and con with the State Dept, of Health and Mental Hygiene prior to burial, CERTIFICATION Sequentially list conditions, AN A CONSEQUENCE OF if any, leading to immediate e. Enter UNDERLYING CAUSE (Diseese or injury other DUE TO (Off AS A CONSEQUENCE OF) thet initieted eventa resulting in death) LAST 6 injury, centributing to death but not resulting in the underlying cause given in Part I. II. Other significant conditions MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY Cum Denich shows any 1 TYES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \( \Boxed{1}\) NO \( \Boxed{1}\) UNCERTAIN \( \Boxed{1}\) PHYSICIAN: 23 26. PLACE OF DEATH /Check only one item 25. WAS CASE REFERRED TO MEDICAL HOSPITAL 1 TYES 2 THO 1 Dipatient 2 ER/Outpatient 3 DOA reing Home 5 - Residence 6 - Other (Specify) a the 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED is marked, 1 Netural 1 YES 2 NO DIRECTOR: After the hours after death w BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Aurel Route Number, City or Town, State) 6 Could not be COMPLETED 28 4 Homicide TO THE HOSPITAL OR AT
TO THE FUNERAL DIRECT
De filed within 72 hours a
IMPORTANT: If item 2 29s. CERTIFIER set of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MEDICAL EXAM fion, in my opinion, death occured at the time, data and place, and due to the ca

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 Pages 1, 2, 3 should

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'n.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit por		
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

Heweles Kardall

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1995

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31. DATE FILED (Month, Day, Year)

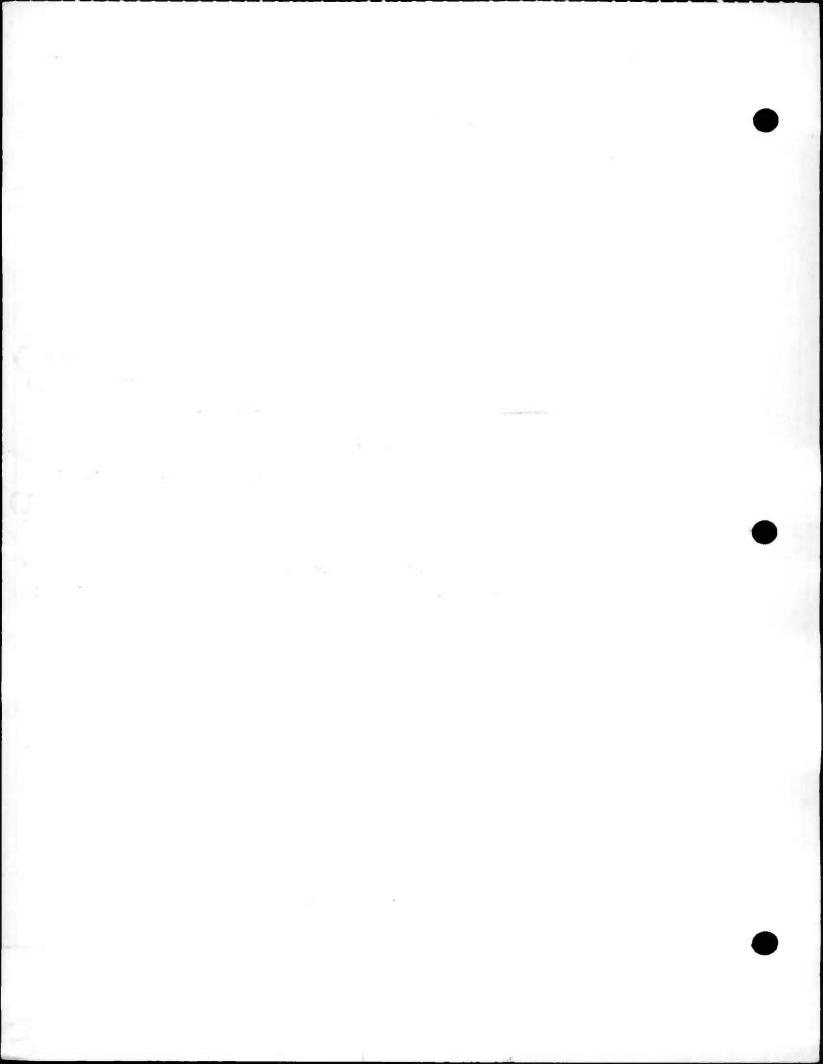
MAY

Item18,19a,b,Film723,5/1/95,1t 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. OECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF GEATH 1995 ELMORE R HAIRSTON III APRIL 0925 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday IF UNDER I YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign DEM 2 F YRS 06 214-43-4072 10-20-94 MD 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR University Hospital Baltimore n/a RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY TOWN OR LOCATION 10d. INSIDE CITY MD Harford Aberdeen 1 YES 2 1 10 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21001 USA 767 Custis St. 12. WAS DECEOENT EVER IN U.S. ARMED 11. MARITAL STATUS 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-it yes, specify Cuban, Maxican, Puerto Rican, stc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 Never Married 2 Married 1 YES 2 NO Specify: Specify: Black BY 3 Wildowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION ETED 15. DECEDENT'S FOUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) n/a n/a COMPL n/a 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) JONES Ħ April Viola James Elmore Hairston, BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Runni Representation). City or Town, State, Zip Code) **JONES** 2 April Viola Custis St. Aberdeem, MD 21001 James pe 20a, METHOD OF DISPOSITION
tXD Burlal 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE must 4 Donation 5 Other (Specify) Daniels Church Cem 4/29 Iron Hill, Deleward St. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AODRESS OF FACILITY James A. Morton & Sons Funeral Homes 1701 Laurens St. Balto. MD 21217 medicai 23. PART i. Errer tha diseasea, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate strock, or heart failure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final **Onaet and Death** the disease or condition CARDIOMYOPATHY 2MONTHS reaulting in death) event, DUE TO (OR AS A CONSEQUENCE OF) 6 MONTHS traumatic COMPLEX CONGENITAL HEART DISEASE CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate 6 MONTHS cause. Enter UNDERLYING TETRASOMY 22 CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa reaulting in death) LAST 6 PART ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMEO? 1 TYES 2 No. NO. 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item HOSPITAL OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 6 28s. OATE OF INJURY (Month, Day, Year) 27. MANNER OF CEATH 28c, INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO BY Investigation 2 Accident 28a. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 99 COMPLETED 8 Could not be 28 4 Homicide Item 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. IMPORTANT: If 2 MEDICAL EXAMINET: On the begit of exa instion and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATING AND TITLE OF CERTIFIE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

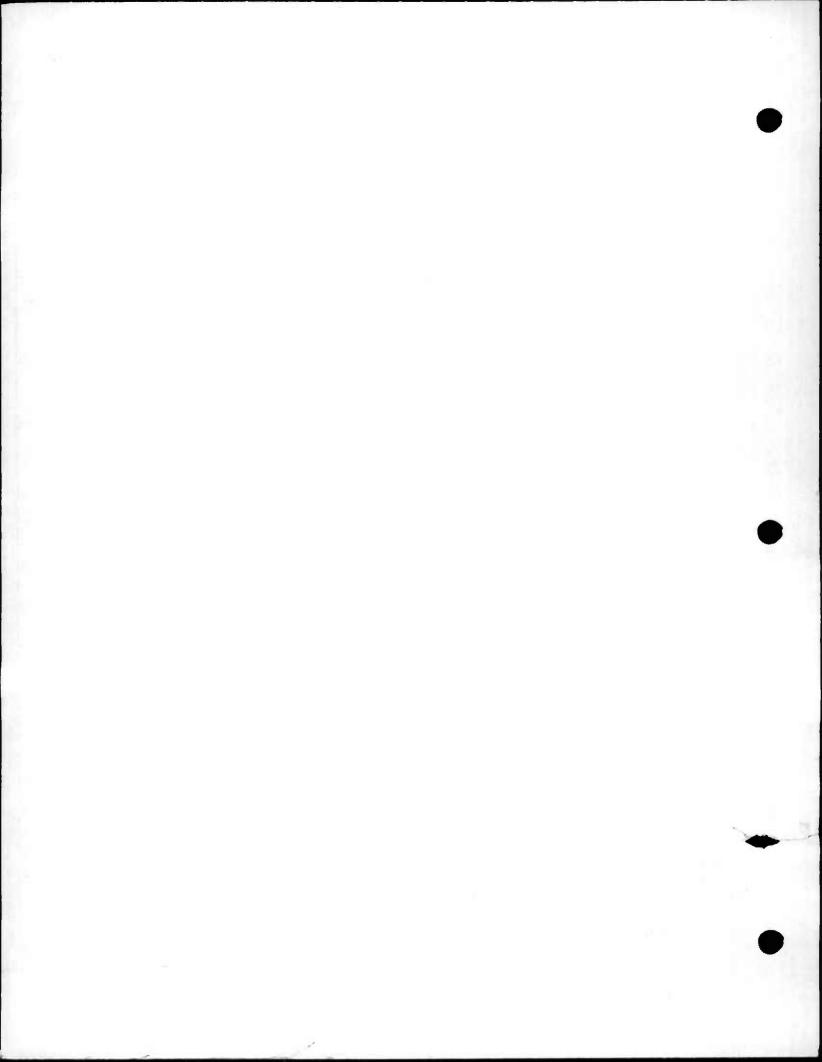
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22. s. GREENE ST BALTIMORE, MD 21201

4/22/95



	1 - STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH / CERTIFICATE OF DEAT	AND MENTAL HYGIENE 'H REG. NO.	
	1. DECEDENT'S NAME (First, Middle, Las		2. DATE OF CEATH MONTH DAY Y	3. TIME OF OEATH
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 2		95 3:35 F
	215-28-3797	1 M 2 HT GH YRS. MONTHS DAYS HOURS	Month, Day, Year)  January 29, 1931	BIRTHPLACE (State or Foreign Country)
СТОВ	90. FACILITY NAME (If not institution, give	mare train	N OF OEATH 9c. COUNTY	201to
DIRECT	10e. STATE 10b. COUN	Balance 10c. OTT, TOWN OR LOCATION / le	<i>.</i>	10d. INSIDE CITY LIMITS?
	10a. STREET AND NUMBER	101. ZIP CODE	10g. CITIZE	1 TYES 2 NO
FUNERAL	7209 Fig.	12. WAS DECEDENT EVER IN U.S. ARMEO 13. WAS DECEMBENT OF	F HISPANIC ORIGIN? (Specify Yea or No.— 14	RACE — American Indian,
B	1 Never Married 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 YES 2 DONO If yes, specify Cuben,	i, Maxican, Puerto Rican, etc.) Specify:	Specify: Black
E	15. DECEDENT'S ED (Specify only highest gra-		16b. KIND OF BUSINESS/INDUS	TRY
COMPLET	Elementary/Secondary (0-12)	Schiller (14 or 34)	se John H	opkins Hosy
111	17. FATHER'S NAME (First, Middle, Last)	Male ak income	ER'S NAME (First Middle, Meiden Stimme)	L
TO BE	1990/INFORMANT'S NAME (Type/Print)	abersham 7209 Pincrest	or Rural Route Number, City or Jown, State, Rip Co	00)md 2122
must be	20a METHOD OF OISPOSITION 1 A Burtal 2 Cremation 3 Re 4 Donation 5 Other (Specify)	amoval from State  20b. PLACE AND DATE OF DISPOSITION (Name of competery) crematory of other place)	SATE 20c. LOCATION - City	y or Yown, State
examiner r	21. SIGNATURE OF UNERAL SERVICE I	as them Albaness	S OF FACILITY	5, 1200
cai exan	1 Dun	12 D- 1 Cott 7350	warbash AV	L
nedic	apock, or near range	r complications that ceused the deeth. Do not enter the mode of dying s. List only one cause on each line.	ng, auch ea cardiec or reepiratory arrest	Approximata Intervei Batwe
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DIVISION OF VITAL RECORDS, P.O. BOX 687

TO BE COME	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
he luneral director, page 5 should be detached	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director. Bage 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or minoral.
er death. Page 6 may be retained by the hosp	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the more after than the law to retained by the host
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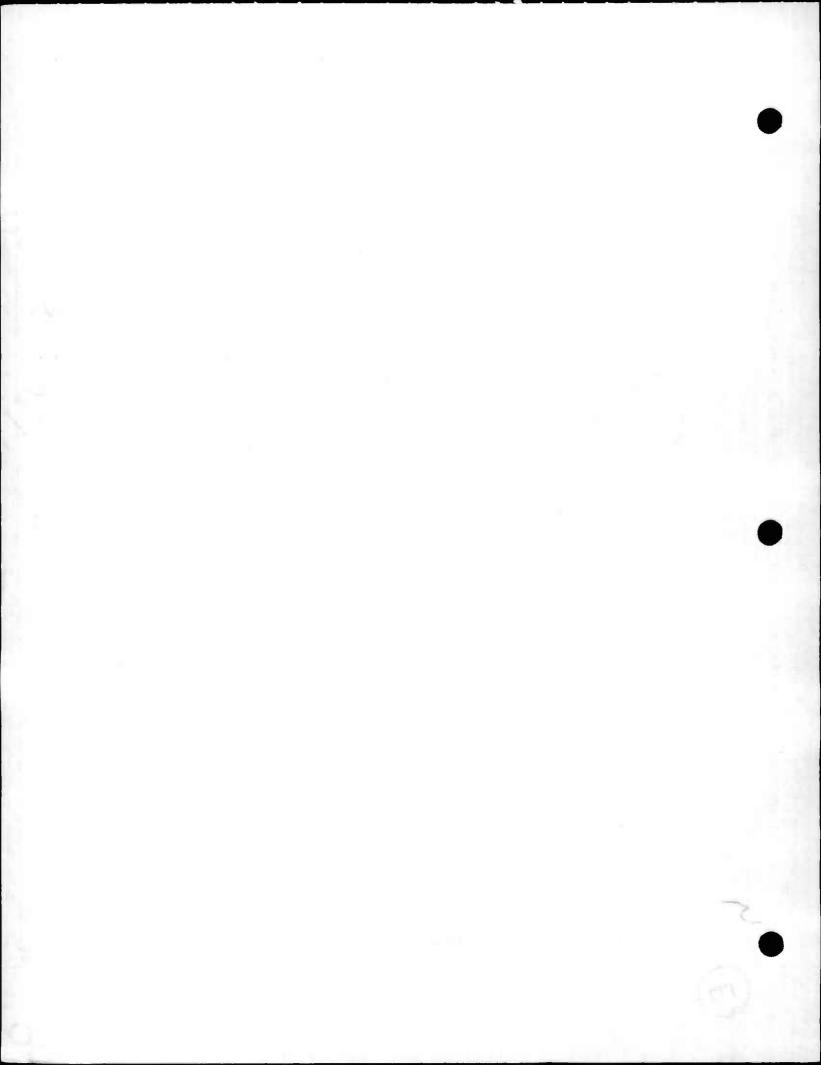
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	1 - FOR STATE REGISTRAR	STATE OF MARYLAND /		OF HEALTH AND	MENTAL HYGIEN		
TO BE COMPLETED BY FUNERAL DIRECTOR	99. FACILITY NAME (If not institution, give street  PESIDENCE OF DECEDENT  109. STATE  109. COUNTY  109. STREET AND NUMBER  11. MARITAL STATUS  1   Never Married 2   Merried  3   Wildowed 4   Divorced  15. DECEDENT'S EQUCATION  (Specify only highest grade come	WAS DECEOENT EVER IN U.S. ARM FORCES? 1   YES 2   YES 1   IF YES, GIVE WAR OR DATES  ON   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. DEC (Gh   Inc.   180. 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CERTIFICATION	23. Feff I. Enter the diseases, or companded, or haert failure. List IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentiely list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF TO (OR AS A CONSE	UENCE OF):	the mode of dying, such		irstory arrest,	Approximate interval Between Onset and Daath Cash
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E COMPLET		: To the best of my knowledge, dear			time, data and place, en	d due to the cause	(e) end menner ee stated.  D (Month, Day, Year)
TO BE	30 NAME AND ADDRESS OF BERRAN WHO CO	lemye	65	1000	359	· 4/	21/95

	in end/or investigation, in my opinion,	death occured at the time, data and	place, and due to the cause(e) and menner ee stated.
UNE AND TITLE OF CENTIFIER	,	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)

32. REGISTRAR'S SIGNATURE 1995



MAY



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

HYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit namer 1.2.3 should	cremation, or removal.	ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be execut	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and c	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic	

	FOR STATE REGISTRAR		STATE OF N	IARYLAI				IEALTH AND	MENTA	AL HYGIEN	_			
	1. DECEDENT'S NAME (First,	Middle, Last)	JOSEPH			RSHAL			MON	E OF DEATH	AY	YEAR	3. TIME OF DEAT	
	4. SOCIAL SECURITY NUMB 223-09-6578	1	5. SEX 1 💢 M 2 🗌 F	6. AGE (In 91	yrs. last birth	RS, IF UN	IDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7 DAT	E OF BIRTH  10. 26, 19		BIRTHP	LACE (State or Fo.	
TOR	Saint Josep RESIDENCE OF DEC	h Medica				9b. C		on Location of C	EATH		9c. COUNT	Y OF DEA		
DIRECTOR	10e. STATE Maryland	10b. COUNTY	nore Cou	ntv			or Locat					- 1"	10d. INSIDE CITY LIMITS?	
	100. STREET AND NUMBER 124 Dunkirk							21212			10g. CITIZE	N OF WH	I YES 2 X	NO
FUNERAL	11. MARITAL STATUS  1 Never Married 2	1	12. WAS DECEDEN FORCES? 1	T EVER IN U	J.S. ARMED 2 NO		If yes, sp	ENDENT OF HISPA	NIC ORIG	IN? (Specify Yes	or No-	U.S. I. RACE - Black,	- American India White, atc.	n,
ED BY	3 Wildowed 4 Divo	DENT'S EDUCAT	TION			NT'S USUAL	1 TYES	2 NO Speci		b. KIND OF BUS	PANEOR (IND.)	Specify:	White	
COMPLET	(Specify only Elementary/Secondary (0	highest grade co.	mpleted) College (1-4 or 5+	,	(Give kin lile. Do N Retai	nd of work do IOT use retire	ne during mo d.)	st of working						
OM	17. FATHER'S NAME (First, MI	ddle, Last)	1		ic tal	r par	Co	16. MOTHER'S NA	_	Publis		Onipa	шу	
BE C	Victor Eman		shauer					France		miodie, marosii	_	cera	a	
70 E	19a. INFORMANT'S NAME (7)	,						nd Number or Rural						
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	21. SIGNATURE OF FUNERAL	SERVICE LICEN	ISEE	2	Lancy	Vall	22. NAME AN	D ADDRESS OF F	ACILITY			те,	Maryla	ICL
	101	uD.	lock	2			6500	hell-Wie York Rd	. Ba	1timor	e. Mar	ylar	nd 2121	2
	23 FART I. Enter the di- shock, or he IMMEDIATE CAUSE (Fin- disease or condition resulting in death)	ei	nplications that it only one cause	se on eaci	h line.			de of dying, suc	ch es ce	rdiec or respi	ratory arres	t,	Approxima Interval Be Onset and YEARS	tween Death
	, acada,		DUE TO	OR AS A C	ONSEQUENC									
NOI	Sequentially list condition		HYPERTO (		ONSEQUENC	CE OF):								
CAT	ceuse. Enter UNDERLYII CAUSE (Disease or Injur	NG	URINAR										2 WEE	KS
CERTIFICATION	thet initiated events resulting in deeth) LAST		ASCITES		ONSEQUENC	CE OF):								
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MED	PRERENAL	AZOTEM	A		111111111111111111111111111111111111111					1 🗌 YES 2	M/NO	0	F DEATH?	
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PHYSICIAN:	EXAMINER?		IOSPITAL:			ОТН	ER:	5 Residence	6   Oth	as (Spacific)				
PH	27. MANNER OF DEATH		28a. DATE OF I	NJURY		TIME OF	28c. INJU	JRY AT		SCRIBE HOW IN	IJURY OCCUP	RED		-
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ETED		could not be etermined	26s. PLACE OF building, s	tc. (Specify)	At home, fa	rm, street, f	actory, office		26f. LOC City	CATION (Street a or Town, State)	nd Number or	Rural Rou	ite Number,	
COMPLET								and place, and due				ause(e) e	nd manner ee sta	rted.
BE	29b. SIGNATURE AND TITLE	OF CERTIFIER	mi	9				29c. LICENSE NUI			29d. DATE S	IGNED (M	Sonth, Day, Year)	5
٩	30. NAME AND ADDRESS OF						ON M	D 21204			/		U · J ~	-
	31. DATE FILED (Month, Day, Y	bar)		EB SIGNATIO		. 0000		J EIEUM						$\dashv$
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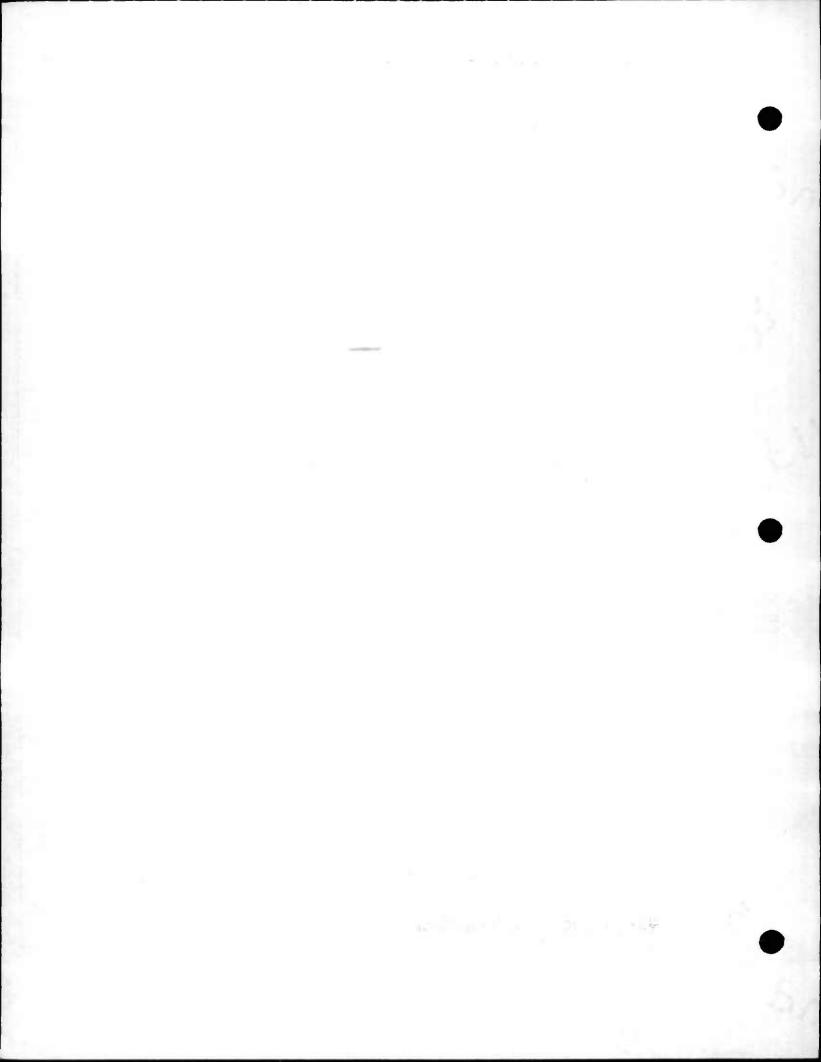
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OF VITAL RECORDS, P.O. I	
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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR ATTEME CATHERINE TOWNES
4. SOCIAL SECURITY NUMBER 5. SEX JACKSON M Q US ? April 1995 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) DAYS 1 M 2 X F 72 212-94-3895 Jan. 19, s. 1923 Carolina burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH Sc. COUNTY OF DEATH DIRECTOR 601 Wyanoke Avenue Baltimore N/A RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD n/a Baltimore 1 X YES 2 NO 10a STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 601 Wyanoke Avenue Apt. 416 21218 U.S.A. hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, While, etc. 1 Never Married 2 Married ΒY 1 TES 2 NO Specify: Specify: 3 X Widowed 4 Divorced page 5 should be detached for use as the Black COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) Private Dury Nurse 6th IN SOMEONE ELSE*S HOME notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname, James Townes Jessie Black 器 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Bobby Jackson 509 Oakland Avenue/Baltimore, MD 21212 þe 20a. METHOD OF DISPOSITION
1 X Burlal 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Sista must funeral director, Baltimore National Cem. Baltimore, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY March Funeral Home East 1101 E. North Avenue/Baltimore, MD 21202 filled in by the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or haart failure. List only one cause on each line 8 Interval Between IMMEDIATE CAUSE (Final Onsat and Dasth been signed by the attending physician and completely filler it. of Health and Mental Hygiene prior to burial, cremation, the disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): 9 me within event, executed traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate 8 cause. Enter UNDERLYING death certificate CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 PART II. Other significant conditions contributing to death but not reaulting in the underlying cause given in Part I. the MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? PERFORMED? shows any 1 TYES 2 NO 1 TES NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has be Dept. ₩0 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OR ATTENDING PHYSICIAN: The this certificate h with the State [ Item HOSPITAL: OTHER: 1 - YES 2 NO 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 10 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 1 Natural 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, 5 Pending ВҰ 1 YES 2 NO After t Investigation Accident ) THE HOSPITAL OR ATTENDIN ) THE FUNERAL DIRECTOR: Af 8 filed within 72 hours after de Suicide 26s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 18 COMPLETED 6 Could not be 4 Homicide datarmined Hem 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE FUNERAL C
TO THE FUNERAL C
DE filed within 72 h
IMPORTANT: If II 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIED BE 29c. LICENSE NUMBER 29d. DATE SINNED (Momph, Day, Year) 396 97 0 ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 30. NAME 2/23 3. REGISTRA'S SIGNOURE 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.  TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit perbefled within 72 hours after death with the State Dept. of Health and Mential Hydrene prior to burial, cremation, or removal.
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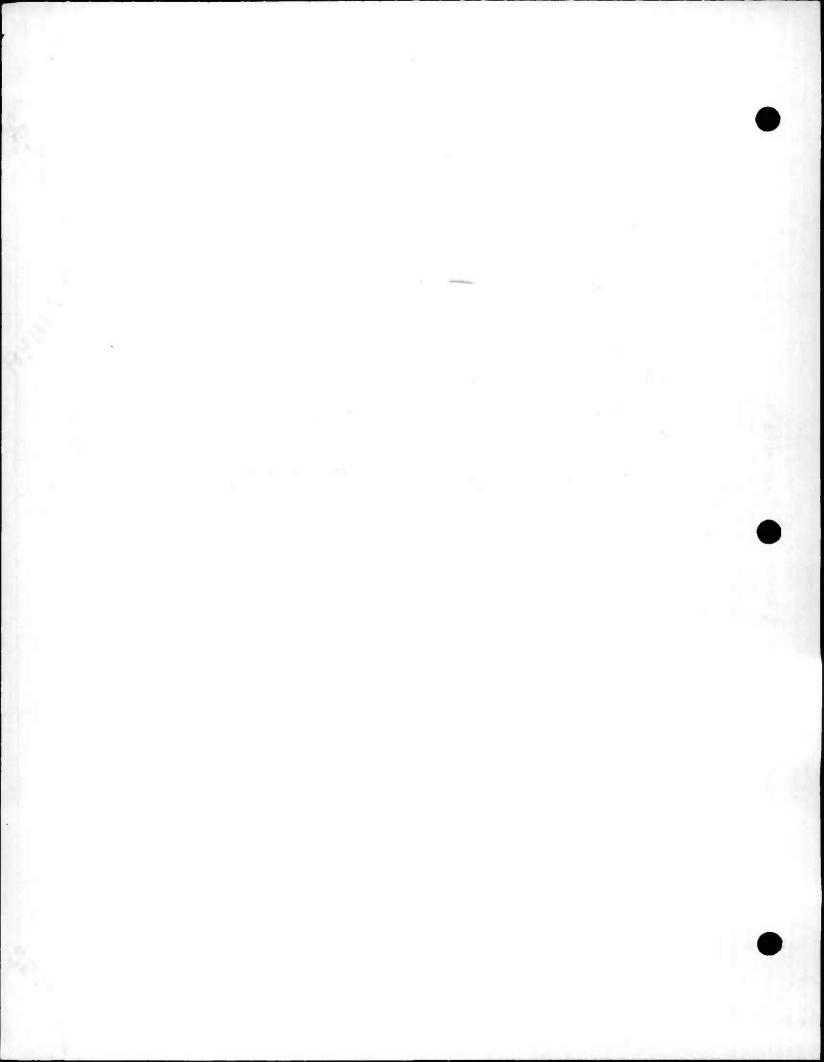
Item#12.G-film 723 per F.H 5/1/95 P.C FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATN YEAR JOHNSON JACKSON APRIL 28 1995 7:15 A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday, IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) S. BIRTNPLACE (State or Foreign 245-32-2815 1 M 2 - F 3-25-2 9s. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR 2614 GROGAN BALTIMORE CITY N/A 10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? md 131/10 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10g, CITIZEN OF WHAT COUNTRY? 2614 212/3 4.5.A 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 2 40 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Maxican, Puarto Rican, stc.)
1 YES 2 100 Specify: 14. RACE — American Indian, 2 Married 1 Never Married IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY dary (0-12) College (1/4 or 5+) 17. FATHER'S NAME (First, Middle, Last) BE 2 20a. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Na SOATE urial 2 Cremation 3 R on 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY BeTTS - 417 CRA N. CARoline 1129 13 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Intarval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition Metastatic resulting in desth) DUE TO (OR AS A CONSEQUENCE OF) PHYSICIAN: MEDICAL CERTIFICATION Sequantisity list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, lasding to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? PERFORMED? 1 TES 2 NO 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) **EXAMINER?** HOSPITAL 1 TES 2 XNO 4 Nursing Nome 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 27. MANNER OF DEATH 26s. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 2 Accident M 1 YES 2 NO В 3 🗌 Suicide 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide datermined 29s. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On this basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER AGNOLS, Itturan BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Morth, Day, Year) Attending 95 DI 7207 28 2 30. NAME AND ADDRESS OF PERSON THO COMPLETED CAUSE OF DEATN (ITEM 27) (Typ), Print) DAVID

Hopkins ONCOlogn

32 REGISTRAR'S SIGNATURE

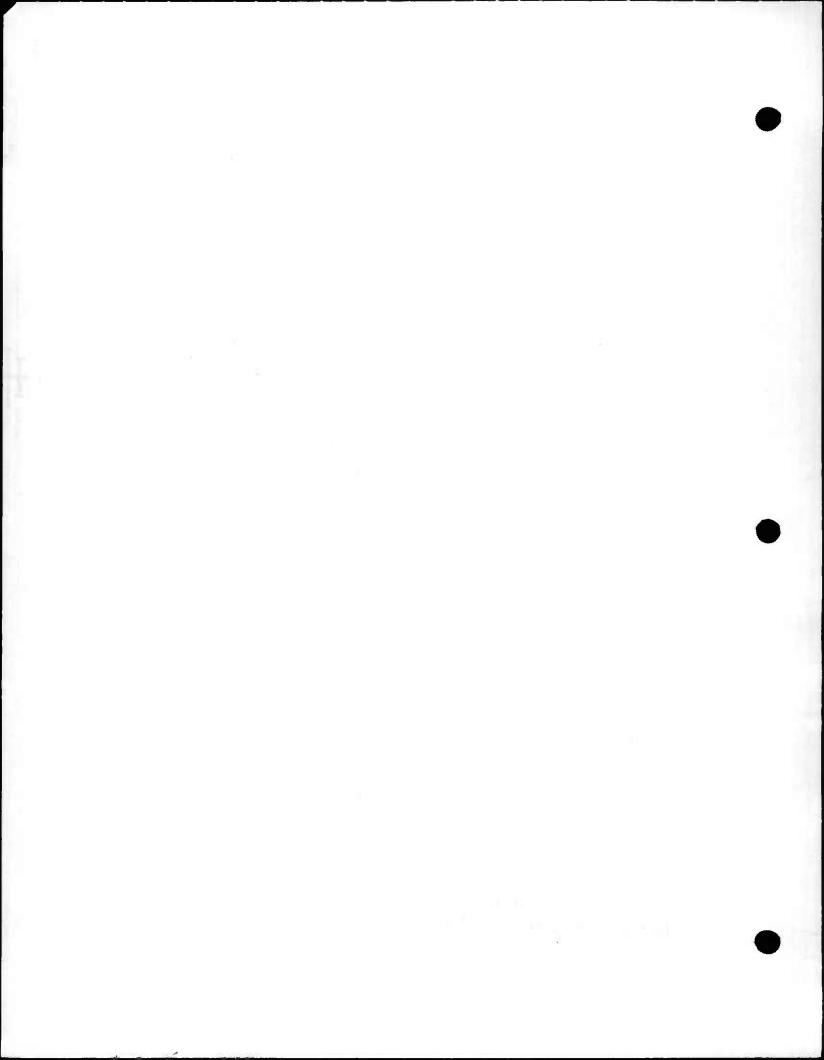
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TO BE COMPLE	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
medical examiner must be notified at once.	PORTUNE II item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
or removal.	TOWNE FUNERAL, DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for the mention of removal.
nours after death. Page 6 may be retained by the hospital	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital o

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF I	HEALTH AND	MENTAL HYGIE						
	1. DECEDENT'S NAME (First, Middle, Lest)					2. DATE OF DEATH		3. TIME OF DEATH				
	RUFUS		JEFFE	RSON		APRIL 2	8, 1995	3:15 a m				
	4 SOCIAL BECURITY NUMBER 578 - 07 - 2295	5. SEX 6. AGE (In yrs. last birthday) F UNDER 1 M 2 F 79 YRS. MONTHS			IF UNDER 24 HRS. HOURS MIN.	7. DATE OF SIRTN (Month, Dey, Wear) December 15, 1915  S. C						
~		ACILITY NAME (If not institution, give street and number)  9b. CITY, TOWN OR LOCATIO						_ Decoulated IO, IDIQ				
OTO	Md General Hos	General Hospital Baltimore						N/A				
DIRECTOR	10a. STATE 10b. COUNTY	N/A		y, town or Loca ltimore	TION	10d. INSIDE CITY LIMITS?						
	10s. STREET AND NUMBER	11771	- 04		f. ZIP CODE	1 🔀 YES						
FUNERAL	1721 W. Lafayette	Street			21217			S A				
BY FU	11. MARITAL STATUS 1	12. WAS DECEDENT EVER IF FORCES? 1XX YES IF YES, GIVE WAR OR DA	2 NO	If yes, sp	CENDENT OF NISPA Healty Cuben, Maxic 2 X NO Speci	NIC ORIGIN? (Specify an, Puerto Rican, etc.) /y:	Yes or No- 14	Black, White, atc.  Specify: Black				
ED	15. DECEDENT'S EDUC (Specify only highest grade of	ATION	16a. DECEDENT'S	USUAL OCCUPATI	ON	166. KIND OF 1	USINESS/INDUS	TRY				
COMPLETED	Elementary/Secondary (0-12) 3rd grade	College (1-4 or 6+)	Steel W	work done during m se retired.) lonker	ost of working	Rethle	nem Ste	ρÌ				
OM	17. FATNER'S NAME (First, Middle, Lest)	N/A	30001 7	TOT KCT	18 MOTHER'S NO							
BE C	Unknown	-			Elle	n J. Thoma	as					
10	190. INFORMANT'S NAME (Type/Print) Ellen Wilkins		196. MAILING 20 E	ADDRESS (Street )	ond Number or Aurel Street I	Richmond, V	dwn, State, zip co la 2322	24				
	20a. METHOD OF DISPOSITION  1) Burlel 2 Crematton 3 Ramo 4 Donation 6 Other (Specify)	val from State 20b	PLACE AND DATE	of disposition (Ni	ame of Ery		ansdown					
	21, SIGNATURE OF FUNERAL SERVICE LICE			22. NAME A	ND ADDRESS OF FA			,				
	e terme +	t. Drimps	m Ja	March 4300			altimore	e, Md 21215				
	23. PART I. Enter the diseases, or co	omplications that caused ist only one cause on a	the death. Do	not antar the mo	de of dying, auc	th sa cerdiac or res	piratory arrest	t, Approximate				
	iMMEDIATE CAUSE (Final disease or condition	in only one cause on a	och illia.					Interval Batween Onset and Death				
	resulting in death)	RESPIRATOR	Y FAILUR	RE.				3 days				
z	DUE TO (OR AS A CONSEQUENCE OF):  CEREBROVASCULAR ACCIDENT											
ATIO	Sequentially list conditions, if any, leading to immediate cause. Enter LINDERLYING	DUE TO (OR AS A	CONSEQUENCE O	F):				3 days				
FIC	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events  DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	that initiated events resulting in death) LAST  d.  d.											
CAL C	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. V											
DIC						1 YES	NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
MEDIC	DID TORACCO LICE CONTR	INVITE TO CALLET O						1 - YES 2 - NO				
PHYSICIAN:	DID TOBACCO USE CONTR 26. WAS CASE REFERRED TO MEDICAL		F DEATH YE		UNCERTAI	N D						
SIC		HOSPITAL:		OTHER:	e 5 - Residence	8 Other (Specify)						
H	27. MANNER OF DEATN	26s. DATE OF INJURY (Month, Day, Year)	26b. TIM	E OF 28c. INJ		28d. DESCRIBE NOV	INJURY OCCUR	EO				
ВУ	12∑Netural 5 Pending 2 Accident Investigation			M 1 🗆	YES 2 NO							
	3 Suicide 6 Could not be 4 Nomicide determined	28a. PLACE OF INJURY building, etc. (Spec	— At home, farm, (	street, factory, offic		28t. LOCATION (Stree City or Town, Sta	t and Number or I te)	Rural Route Number,				
E COMPLETED		tAN: To the best of my knowl						ause(s) and manner as atated.				
9	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI			IGNED (Month, Day, Year)				
_#C		udellua			892			28-95				
0	30. NAME AND AODRESS OF PERSON WNO INNA GENDELSMAN	COMPLETED CAUSE OF DEA	ATN (ITEM 27) (Type,	Print)			4-/	70-3)				
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO. 1 DECEDENT'S NAME /First Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 APRIL 27 DEWEY JOSEPH LOSELLE JR 1:21 PM 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH 1423 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign 1 M 2 - F MONTHS DAYS HOURS YRS. December YORK 17 New 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY RESIDENCE OF DECEDENT 10e. STATE 10h. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY VirgINIA MANAGSAS 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 9406 NELSON S ANE A 18 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Ye It yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 W Married 1 YES 2 NO BY Specify: 3 Widowed 4 Divorced WHITE ETED 16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EOUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest (Give kind of work done life. Do NOT use retired.) econdary (0-12) College (1-4 or 5+) COMPL once. 17. FATNER'S NAME (First, Middle, Last) LOS MMERS EWE notified at ANN BE INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Nu 2 Pe METHOD OF DISPOSITION 20e. METNOD OF DISPOSITION
1 L Buriet 2 Cremetton 3 20b. PLACE AND DATE OF DISPOSITION (Name of may 1, OATE - City or Town, State must ANTICO NAT 5-1 Donation 5 Other (Specify) 1995 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY asus medicai 23. PART I. Enter the diseases, or complicatione that caused the death. Do not enter the mode of dying, such as cardiec or reepiratory arrest, Approximate shock, or haart failure. List only one ceuse on each line. Intervel Between IMMEDIATE CAUSE (Final Onaat and Daath the state diseese or condition NON HODGKINS LYMPHOMA reaulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY PERFORMEO? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 - YES 2 X NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO INCERTAIN I PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) EXAMINER? HOSPITAL: OTHER:
4 \subseteq Nursing Home 5 \subseteq Residence 8 \subseteq Other (Specify) 1 YES 2 X NO 1 Kinpatient 2 ER/Outpatient 3 DOA 27. MANNER OF OEATN 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 X Natural 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, atreet, fectory, office building, etc. (Specify) 3 Sulcide 28t. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29e, CERTIFIER 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the ceuse(s) and manner ea stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 104 27

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BETHESDA, MD 20899-5600

NATIONAL NAVAL MEDICAL CENTER

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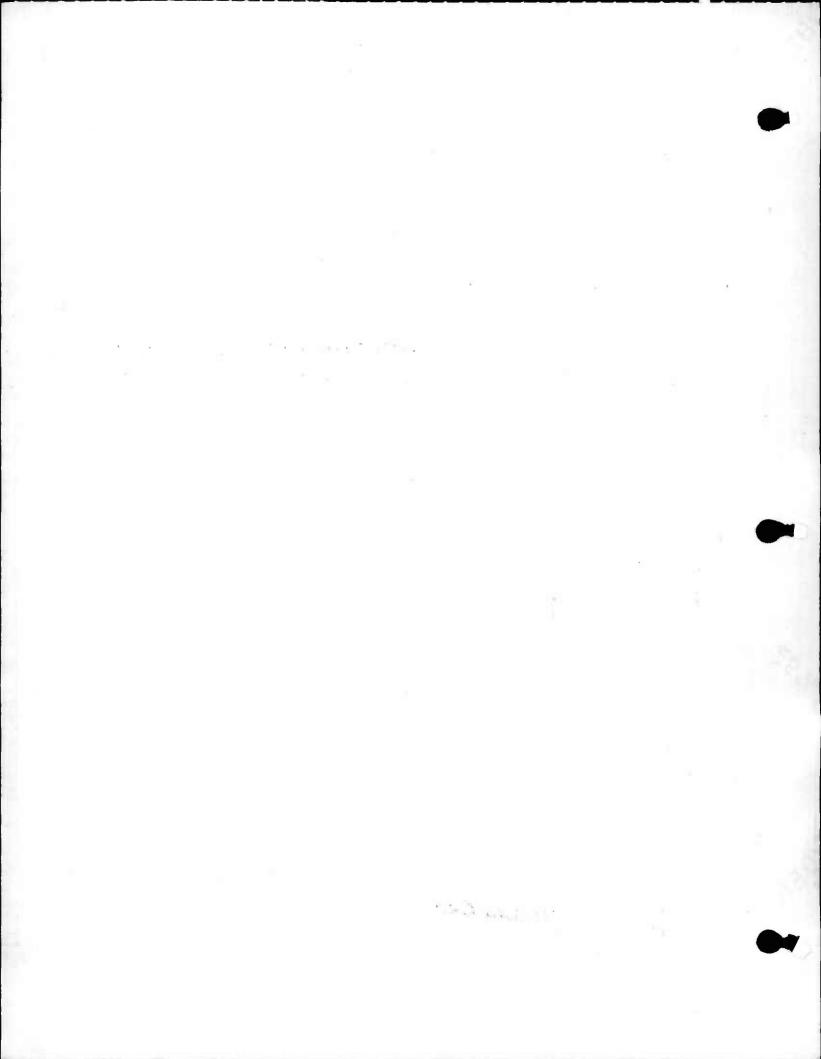
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30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

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CERTIFICATION

MEDICAL

PHYSICIAN:

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1 Natural 2 Accident

3 Suicide

4 Homicide

29a. CERTIFIER

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital o	FUNERAL OIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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오	문불

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN YEAR Apr 27 1996 LUMARO SALVATORE 6:17 am М 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 10/6/29 5. SEX IF UNDER 24 HRS. 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign 1X M 2 | F MONTHS DAYS HOURS 217-54-4551 65 ITALY 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN Saint Joseph Medical Center Baltimore Towson, Maryland RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY MARYLAND BALTIMORE HILLENDALE 1 YES 2 X NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 7910 HILLENDALE ROAD 21234 ITALY 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, Whita, atc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 3 Widowed 4 Divorced WHITE 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 5th GRADE CEMENT MASON CONSTRUCTION 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) FILIPPO LUMARO CONCETTA BARRESI 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARIA LUMARO 7910 HILLENDALE ROAD HILLENDALE, MD 21234 20a. METHOD OF DISPOSITION
1 ☑ Burlel 2 ☐ Cremation 3 ☐ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION /Nama of 20c. LOCATION - City or Town, State ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 4/29/95 BALTIMORE, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY JOHNSON FUNERAL HOME Kustina 1000 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximeta shock, or heart fellure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Final **Onset and Death** disesse or condition___ 1 DAY **ACUTE MYOCARDIAL INFARCTION** resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IX UNCERTAIN I 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) NOSPITAL:
1/2 inpatient 2 | ER/Ouipatient 3 | DOA 1 YES 2 NO OTHER: 4 Nursing Home 5 Residence 8 Other (Specify)

27, MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year)

Investigation

8 Could not be

28b. TIME OF 28c. INJURY AT WORK?

1 YES 2 NO 28a. PLACE OF INJURY — Al home, farm, streel, factory, offica building, stc. (Specify)

29c. LICENSE NUMBER

D 30283

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

28d. DESCRIBE NOW INJURY OCCURED

1 CERTIFYING PNYSICIAN: To the best of my knowledge, dash occurred at the time, data and place, and due to the cause(a) and menner as stated.

2 MEDICAL EXAMINER: On the beats of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner ea stated.

Tanns 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

FRANCIS KHOO, M.D., ST. JOSEPH MEDICAL CTR., 7620 YORK RD., TOWSON, MD. 21204

MAY 01 1995

29b. SIGNATURE AND TITLE OF CERTIFIER



29d. DATE SIGNED (Month, Day, Year)

4-27-95

HURSTER SERVICIONAL ISSAULT TO AVUAS

Sent Joseph Veden Sens Sens Patron Parvand Batmole

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FRANCIS KHUDI MID, ST. JOSEPH MEDICAL CTR. 1820 OFK RO. TOWSON MO. 212 M

DIVISION OF VITAL RECORDS, P.O. BOX 68760.	BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within and	A: The law requires that the death certificate be executed within a flor death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fille be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation,	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: II Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	medical examiner must be notified at once.

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	ITEMS: 23 PART ]	CTATE OF	MARYLAND / D	i=723	5/19/9 TMENT O	5 t.t	AND	MENTAL IIV	(OITHE		
	1 - STATE REGISTRAR	SINIE OF I	CEF	RTIF	ICATE (	F DEA	TH		G. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DE		a	. TIME OF DEATH
	ELSIE	MON	ROE					APRIL	25 19	YEAR	
	4. SOCIAL SECURITY NUMBER	RITY NUMBER 5. SEX 6. AGE (In yrs. In				and high-day)				95	12:00 P A  ACE (State or Foreign
	213-64-3541	1 🗆 M 2 📈 F	410	SI birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.  MONTHS DAYS HOURS MIN.			7. DATE OF BH (Month, Day.	Year)	Country)	ACE (State or Foreign	
			72					12-1		m	4
~	9a. FACILITY NAME (If not institution, give at 639 GUTMAN AVE		- 1		N OR LOCAT			9c. COUNTY OF DEATH			
0				DALI.	MORE	C1	ΙΥ		NI	A	
D D	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY			the CITY	Y, TOWN OR LO	CATION			AND INDIPERIENT		
DIRECTOR	md.	n//A			BA				10d. INSIDE CITY LIMITS?		
	10e, STREET AND NUMBER				1000	10f. ZIP COD	•				YES 2 NO
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FUNERAL	11. MARITAL STATUS		-1-				212				5 · A.
E	1 Never Married 2 Married	FORCES?	NT EVER IN U.S. ARME	D	13. WAS	DECENDENT ( specify Cubi	OF HISPAI en, Mexico	NIC ORIGIN? (Spe	elfy Yea or No-	14. RACE - Black, Y	- American Indian, White, etc.
BY	3 Widowed 4 Divorced		MAR OR DATES			YES 2 NO				Specify:	
	15. DECEDENT'S EDUC	2471011			1					13/1	rec_
ETED	(Specify only highest grade	completed)	(Give	kind of w	VSUAL OCCUP		ing	18b. KIND	OF BUSINESS/IND	JSTRY	
ا ت	Elementary/Secondary (0-12)	College (1-4 or 5	+)	1	e retired.)			7	11/1	100	į
COMPL	12	IV/H	40	bo	r			-4	Maus	TRY	
8	17. FATHER'S NAME (First, Middle, Last)					16. MOT	HER'S NA	ME (First, Middle,	Maiden Sumame)		
B	George HA	KR.S					1901	en -	Tickle	5	
2	19a. INFORMANT'S NAME (Type/Print)		19b. A	MAILING	ADDRESS (Str	et and Numbe	r or Rural	Route Number, City	y or Town, State, Zip		
-1	LOWISE GA	219	4	45	5 W	Rene	1000	LAVE,	BA110.	mel	-21212
- 1	20s. METHOD OF DISPOSITION	med trom State	20b. PLACE AND	DDATEC	FDISPOSITIO	(Name of		DATE	20c. LOCATION — C		
	1) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BA 170 MA.									d.	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE				AND ADDRE			,		
	Nation 3	12.46	-		B	115	Fan	eral	Hone	-	
	Jamen	DIE			113	9N.	CA	coline	st.		
- 1	23. PART I. Enter the diseases, or o shock, or heart failure.	omplications the List only one car	it caused the deat! use on each line.	h. Do n	ot enter the	mode of dy	ing, suc	h as cardiac o	r respiratory arre	et,	Approximate interval Between
	IMMEDIATE CAUSE (Final			B.							Onset and Death
	disease or condition resulting in death)	CIRRHOS	SIS OF THE L	LIVER							
		DUE TO	(OR AS A CONSEQUE	ENCE OF	7):						<u> </u>
z											
CERTIFICATION	Sequentially list conditions, If any, leading to immediate										
8	cause. Enter UNDERLYING										
Ē	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):										
E	that initiated events resulting in death) LAST										
2	d										
A	PART ii. Other significant conditions contributing to death but not resulting in the underlying cause give								MAS AN AUTOPSY PERFORMED?		ERE AUTOPSY FINDINGS MILABLE PRIOR TO
용									YES 2 NO	CO	OMPLETION OF CAUSE
E I											F DEATH?
-	DID TOBACCO USE CONTR	RIBUTE TO CA	USE OF DEATH	ł YF	S I NO		ERTAII				_ 123 2 _ 110
₹ I	25. WAS CASE REFERRED TO MEDICAL				H (Check only		- CIVITAI				
PHYSICIAN: MEDICAL	EXAMINER?	HOSPITAL:	ER/Outpetient 3 🗆	DOA	OTHER:	. X		8 Other (Spec			
¥	27. MANNER OF DEATH	28a. DATE OF		8b. TIME		INJURY AT	rsidence		HOW INJURY OCC		
	1 Natural 5 Pending	(Month, D		INJ	URY	WORK?	7 400	200. DESCRIBE	HOW INJURY OCC	NHED	
BY	2 Accident Investigation	200 DI ACE (	OF IN HIPM	4			_ NO				
	3 Suicide 8 Could not be 4 Homicide determined	building,	of INJURY — At home, etc. (Specify)	, rarm, \$	treet, rectory, o	THE		28f. LOCATION City or Town	(Street and Number ( 1, State)	or Rural Rout	te Number,
COMPLETED			-								
길			my knowledge, death								
0	one) 2 MEDICAL EXAMINE										nd manner as stated.
- 11											
H	29b. PATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Voer)										

NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

A LANGE FILED (Month, Day has

31. DATE FILED (Month, Day has

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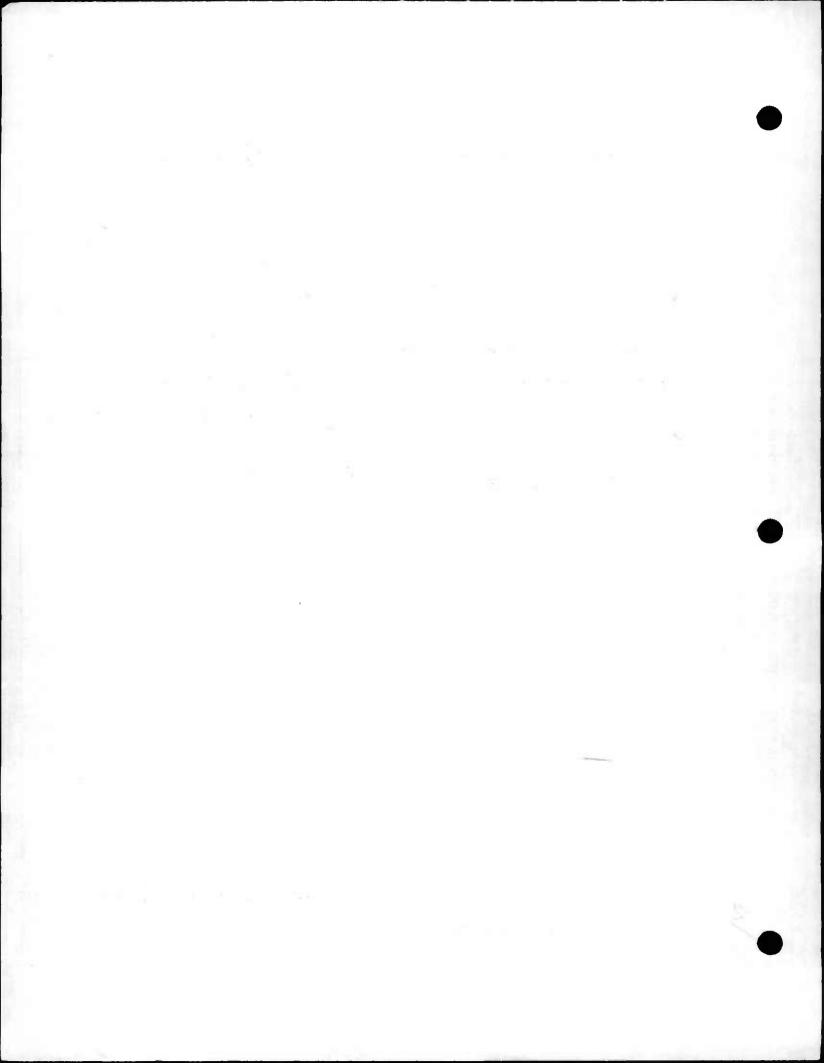
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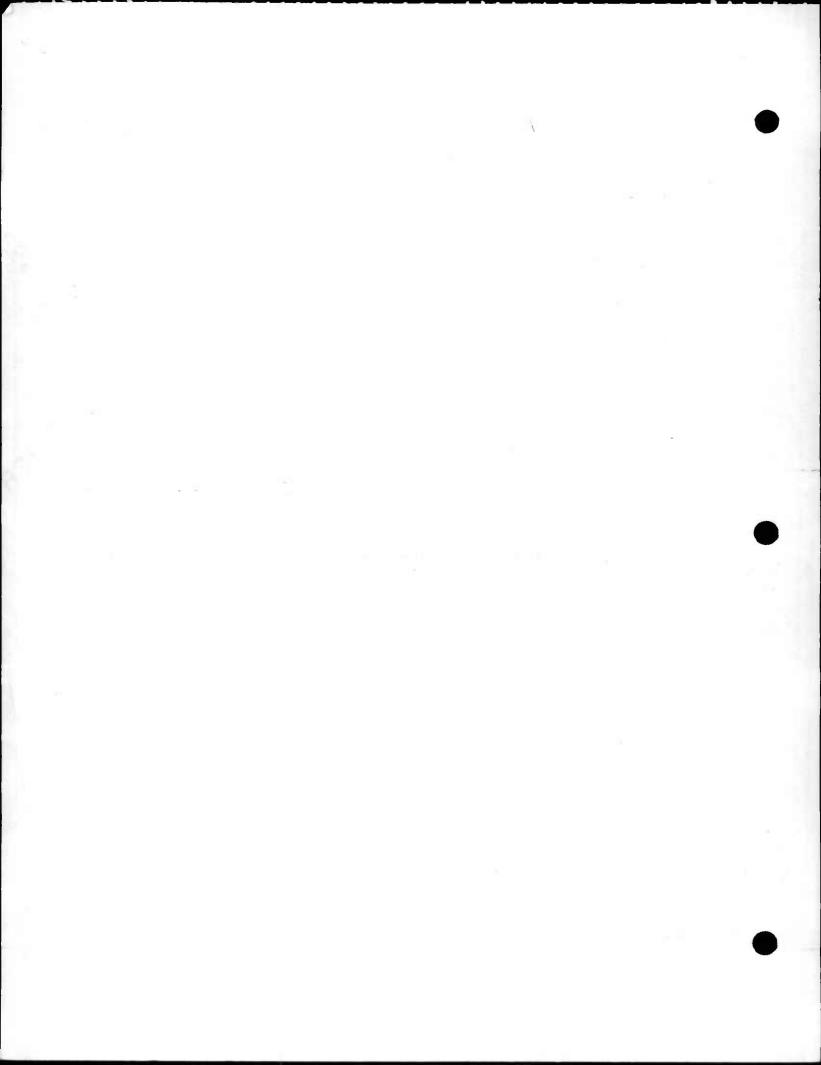
PLEATE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 frouts after death. Page 6 may be retained by the hospital or attending physician.

INTERING DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

WHILL IN IEEM 28 is marked, or IEEM 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MAY 01

	1 - FOR STATE REGISTRAR	TATE OF MARY			IENT OF H	EALTH AND M	ENTAL HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)  Dorothy	111 m	a sel e	24		8	2. DATE OF DEATH		3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 5. S		arsha GE (In yrs. last b		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH			M
	210 40 3337	M 2 XF 4	6	YRS.	NTHS DAYS	HOURS MIN.	(Month, Day, Year) 7/27/1948	F	SALTIMORE, MD.	
E	9a. FACILITY NAME (If not institution, give street en	AT LETTIN		96		IMORE	ТН	S. NO.  STH DAY  TO THE DAY  TO THE DAY  TO THE DAY  TO THE DAY  TO THE DAY  TO THE DAY  TO THE DAY  TO THE DAY  TO THE DAY  S. BIRTHPLACE (State or Foreign  BALTIMORE, MD.  9c. COUNTY OF DEATH  CITY  10d. INSIDE CITY  LIMITS?  1 (A PER 2 In NO  10g. CITIZEN OF WHAT COUNTRY?  USA  10g. CITIZEN OF WHAT COUNTRY?  USA  11d. RACE — American Indian, Black, White, etc.  Specify:  ARF. AMERICAN  OF BUSINESS/INDUSTRY  SEKEEPING DEPT.  10d. INSIDE CITY  LIMITS?  1 (A PER 2 In NO  10g. CITIZEN OF WHAT COUNTRY?  USA  11d. RACE — American Indian, Black, White, etc.  Specify:  ARF. AMERICAN  OF BUSINESS/INDUSTRY  SEKEEPING DEPT.  10d. INSIDE CITY  LIMITS?  1 (A PER 2 In NO  10g. CITIZEN OF WHAT COUNTRY?  USA  11d. RACE — American Indian, Black, White, etc.  Specify:  ARF. AMERICAN  OF BUSINESS/INDUSTRY  SEKEEPING DEPT.  10d. INSIDE CITY  LIMITS?  1 (A PER 2 IN NO  10d. INSIDE CITY  LIMITS?  1 (A PER 2 IN NO  10d. INSIDE CITY  LIMITS?  1 (A PER 2 IN NO  10d. INSIDE CITY  LIMITS?  1 (A PER 2 IN NO  10d. INSIDE CITY  LIMITS?  1 (A PER 2 IN NO  10d. INSIDE CITY  LIMITS?  1 (A PER 2 IN NO  10d. INSIDE CITY  LIMITS?  1 (A PER 2 IN NO  10d. INSIDE CITY  LIMITS?  1 (A PER 2 IN NO  10d. INSIDE CITY  LIMITS?  1 (A PER 2 IN NO  10d. INSIDE CITY  LIMITS?  1 (A PER 2 IN NO  10d. INSIDE CITY  LIMITS?  1 (A PER 2 IN NO  10d. INSIDE CITY  LIMITS?  1 (A PER 2 IN NO  10d. INSIDE CITY  LIMITS?  1 (A PER 2 IN NO  10d. INSIDE CITY  LIMITS?  1 (A PER 2 IN NO  10d. INSIDE CITY  LIMITS?  1 (A PER 2 IN NO  10d. INSIDE CITY  LIMITS?  1 (A PER 2 IN NO  10d. INSIDE CITY  LIMITS?  1 (A PER 2 IN NO  10d. INSIDE CITY  LIMITS?  1 (A PER 2 IN NO  10d. INSIDE CITY  LIMITS?  1 (A PER 2 IN NO  10d. INSIDE CITY  LIMITS?  10d. INSIDE CITY  10d. INSIDE CITY  10d. INSIDE CITY  10d. INSIDE CITY  10d. INSIDE CITY  10d. INSIDE CITY  10d. INSIDE CITY  10d. INSIDE CITY  10d. INSIDE CITY  10d. INSIDE CITY  10d. INSIDE CITY  10d. INSIDE CITY  10d. INSIDE CITY  10d. INSIDE CITY  10d. INSIDE CITY  10d. INSIDE CITY  10d. INSIDE CITY  10d. INSIDE CITY  10d. INSIDE CITY  10d		
5	UNIVERSITY HOSPITA RESIDENCE OF DECEDENT  10e. STATE  10b. COUNTY	<u>.L</u>					·	CIII	S. BIRTHPLACE (State or Foreign Country)  BALTIMORE, MD.  ITY OF DEATH  YY   10d. INSIDE CITY LIMITS? 1  YES 2  NO  PEN OF WHAT COUNTRY?  14. RACE — American Indian, Black, White, etc.  Socily: ARF. AMERICAN  JUSTRY  IG DEPT.  Code)  ARYLAND 21217  City or Town, State MARYLAND  P. A. MARYLAND 21217  City or Town, State MARYLAND  P. A.  Approximate Interval Between Onset and Death 2 days  4 days  4 days  1  Yes 2 No  URED	
DIRECTOR	BALTIMORE CITY				OWN OR LOCAT				LIMITS?	AMERICAN  AMERICAN  AMERICAN  Approximate interval Between Onset and Death  2 days  4 days  4 days  4 days  FREE AUTOPSY FINDINGS WAILABLE PRIOR TO OMPLETION OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF TO OMPLETION OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO OF CAUSE FOR ATTO
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3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify:							Black, White, etc.			
		N	16a DECE	FDENT'S LISE	IAL OCCUPATION	N.	165 KIND OF BUIL	-		I
COMPLETED	(Specify only highest grade compliance (Specify only highest grade compliance)  Elementary/Secondary (0-12)  Coll	lege (1-4 or 5+)	(Give	kind of work to NOT use re	done during mo tired.)	st of working	166. KIND OF BU	SINESS/INDUS	SIMY	
MP	12 0	)	UNIV	ERSIT	Y OF M	ARYLAND			G DEPT.	
	17. FATHER'S NAME (First, Middle, Lest)  BERNARD MORANT					18. MOTHER'S NAME MARIE	E (First, Middle, Meiden HALL	Sumeme)		
TO BE	19e. INFORMANT'S NAME (Type/Print)									
	REBECCA MILLER 200. METHOD OF DISPOSITION	1.	18 20b. PLACE AND							
- 1	1 Donation 5 Other (Specify)					RY 4/21/9				
	21. SIGNATURE OF FUNERAL SETRICE LICENSE	5 1	7		22. NAME AN ESTEP	BROTHERS	FUNERA1	HOME.	P.A.	
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	23. PART I. Enter the ciseases, or compl shock, or feert fellure. List of	lications that caus only one cause on	sed the deat n eech iine.	th. Do not	enter the mo				interval Between	en
	immediate cause (Finel	only one dause on	n eech ilne.						Onset and Dea	en
	iMMEDIATE CAUSE (Finel disease or condition resulting in deeth)	brainsten	n eech iine.	farcti	on	de of dying, such			Onset and Dea	en
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		TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in	'n,
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	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	an an	2
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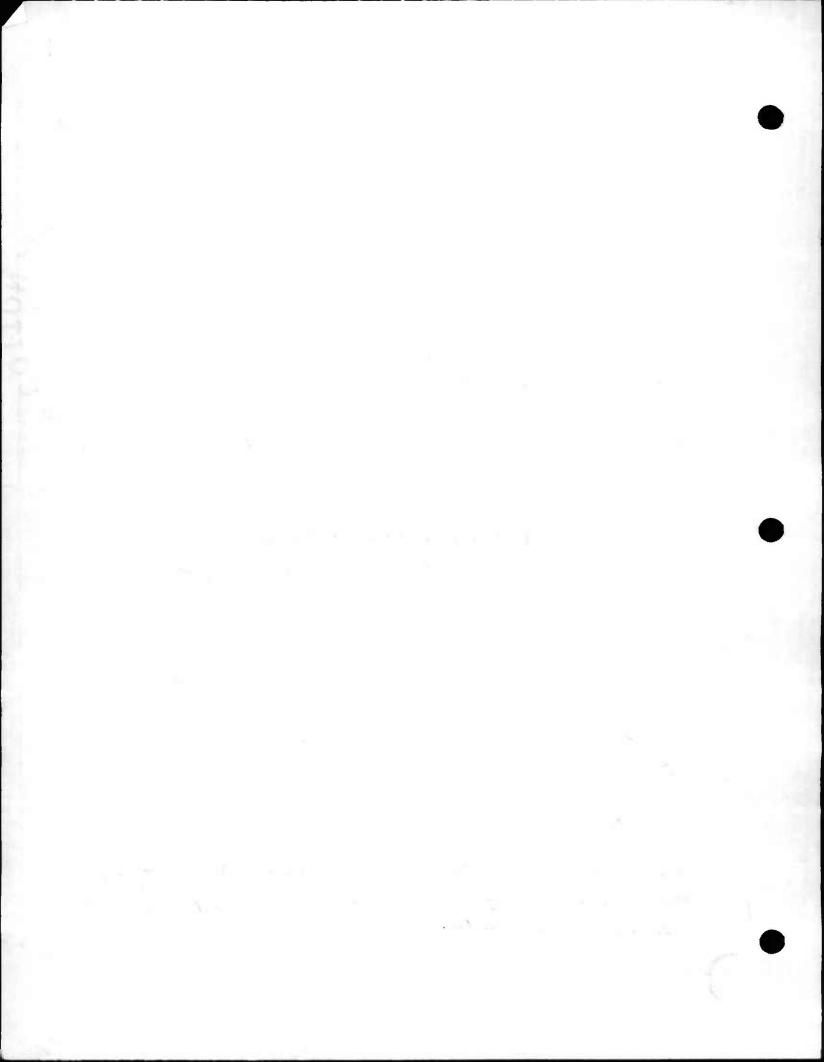
1 - STATE REGISTRAR	14 38					DEATH		HYGIEN REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)	11	ACK E	DNA LUV	ENIA	MACK		2. DATE MONT	OF OEATH		TEAR I	7/4 AM N
4. SOCIAL SECURITY NUMBER 214-12-8176	5. SEX	8. AGE (In yrs. In	st birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	(Mon	OF BIRTH h, Day, Year)		BIRTHP Country)	MARYL A Repign
a. FACILITY NAME (If not institution, give street and number)  1VY HAII GERIATTIC CENTER BALTIMORE MIDDLE RIVER BALT								Y OF DE			
100. STATE 10b. COUNT	Y		10c. CITY	, TOWN C	R LOCATI	ON	-			T	IOd. INSIDE CITY
Maryland C	saltin	MOVE		100	اکاب	ZIP CODE					YES 2 NO
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11, MARITAL STATUS 1 Never Married 2  Merried 3  Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2	PMED NO			NDENT OF HISPAR city Cyban, Mexica 2 NO Specifi	n, Puerto		or No— 1	4. RACE Black, Specify	American Indian, White, etc.
15. OECEDENT'S EDU (Specify only highest grade	completed)	(C	ECEDENT'S Give kind of w e. Do NOT us	ork done	CCUPATIO	t of working	164	. KIND OF BUS	SINESS/INDU	STRY	
Elementary/Secondary (0-12) College (1-4 or 5+)  (a the Grade Dome Strice  NA											
17. FATHER'S NAME (First, Middle, Last) Edward Mack  18. MOTHER'S NAME (First, Middle, Meiden Surneme) BEULCH Watkins									2		
19a. INFORMANT'S NAME (Type/Print)  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
KICHARD L	-88	20b. PLACE	OF DISPOS	ITION (Na	me of com	etery, cremetory or	Ur	20c. LO	CATION — C	ty or Tow	y. Mary/
1 Burial 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	+	PIG	alace)	nt	KES	+ CEI	ne	tary-	Tou	uson	narylan
21. SIGNATURE OF FUNERAL SERVICE LI	ams			22.	NAME AN	ADDRESS OF FA	- L	5340	REIS F.W.	Bau	HIMOR TL
25. PART I. Briter the diseases, prehock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. OSC	elle f	AZUL	7	11	A	n aa car	diac or respi	retory arre	st,	Approximate Interval Between Onset and Deatl
Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that Initiated avents resulting in death) LAST  b. Depends DCAC A  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other algorificant condition	na contributing to	death but not	reaulting i	n tha ur	idarlyling	causa given in	Part I.	24a. WAS AN PERFOR 1 TYES 2	MED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)											
EXAMINER?  1 YES 25 NO	HOSPITAL: 1 Inpetient 2				sing Home		8 Other (Specify)				
27. MANNER OF DEATH  1 Natural 5 Pending Investigation		Day, Year)	28b. TIMI INJ	URY M	WOI	INJURY AT 28d. DESCRIBE HOW INJURY OCCUR WORK?  YES 2 NO			JRED		
29a. CERTIFIER 1 DERTIFYING PHYS 0ne) 2 MEDICAL EXAMIN	ER: On the beels of										and manner as stated.
296. SIGNATURE AND TITLE OF CERTIFIER  296. LICENSE NUMBER  D 1 4 2 2											
30. NAME AND ADDRESS OF PERSON WI	10 COMPLETED CAL	SE OF DEATH (IT	EM 27) (Туре,	Print)							<del>-</del> -
31. DATE FILED (Month, Day, Year) MAY 01 1995	32. RIIGISTH	AR'S SIGNATURE	tL.	-							
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BALTIMORE, MARYLAND 21215-0020	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physici	
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	quires	
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1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		REGISTRAR	CERTIFICATE	OF DEATH	REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last) DAUID Martin	Mctadoe	ر	2. DATE OF DEATH DO NONTH DO	, 1995	3. TIME OF DEATH
Pi		117-56-8335 XM20F 3	GE (In yrs. last birthday)  F UNDER 1 1  MONTHS C	YEAR IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Yan)	1961 M	NPLACE (State or Foreign try)  aryland
1, 2, 3 should	DIRECTOR	99. FACILITY NAME (If not institution, give street end number)  627 N. Carrollto  RESIDENCE OF DECEDENT	n AUE Ba	own or location of o		9c. COUNTY OF	DEATH A
Pages 1	EC	10e. STATE 10b. COUNTY	10c. CITY, TOWN OR	LOCATION			10d. INSIDE CITY
permit. Pag		Maryland MA  104. STREET AND NUMBER	Balti	MORE 101. ZIP CODE		100 CITIZEN OF	LIMITS?  1 YES 2 NO  WHAT COUNTRY?
sit	FUNERAL		AUENUE	2121	7	U	5A
ending physic as the bunal	D BY FU	1 Never Married 2 Married FORCES? 1 YES, GIVE WAR O	res 2 No If y	S DECENOENT OF HISPA ee, specify Cuban, Mexic YES 2 NO Speci		or No— 14. RAC Blac Spec	E - American Indian, oct. White, etc.  Black
al or att for use	LETE	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCI (Give kind of work done duri life. Do NOT use refired)	JPATION ing most of working	AD	CANCE IN ESS	Systems
	E COM	17. FATHER'S NAME (First, Middle, Last) PEYNELL Mc Foodd	en	16. MOTNER'S N	AME (First, Middle, Maiden		
be retained by ige 5 should be notified at	TO B	190. INFORMANT'S NAME (Type/Print)	196. MAILING ADDRESS (S	2 111			21217
death. Page 6 may be funeral director, page examiner must be	1	20e. METHOD OF DISPOSITION  1 Burlel 2 Cremetion 3 Removal from State  Donation 5 Other (Specify)	20b. PLACE AND DATE OF DISPOSITION COMPLETE, crematory of other place)			CATION — City or T	own, State
Page al din		21. SIGNATURE OF FUNEBAL SERVICE LICENSEE		ME AND ADDRESS OF F	CILITY COLOR	CICTOR	Lillary Icho
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ted within 24 hours after completely filled in by the ial, cremation, or removal : event, the medical		23. PART I. Enter the diseases, or complications that ceu shock, or heart failure. Liet only one cause of IMMEDIATE CAUSE (Finel disease or condition resulting in death)  DUE TO (OR A	used the deeth. Do not enter the neach line.  Le Preudas A CONSEQUENCE OF:	monia	2		Approximate Interval Between Onset and Death
ficate be execu physician and ne prior to bur her traumation	CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events  DUE TO (OR A	AS A CONSEQUENCE OF):	no defic	iency Si	zndro.	ze.
E 8 - 0	#	resulting in death) LAST					
0 0	- 1	PART II. Other aignificent conditions contributing to deet	th but not resulting in the unde	riving cause given in	Part I, 24s. WAS AN	ALITOPSY 244	D. WERE AUTOPSY FINDINGS
ires that signed by leafth an	EDICAL				PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
VSICIAN: The law requi s certificate has been s th the State Dept. of H d, or Item 23 shov	ž	DID TOBACCO USE CONTRIBUTE TO CAUSE	OF DEATH YES INC	UNCERTAI	<u> </u>		1 TES 2 NO
The law te has b te Dept	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF DEATN (Check only				
trificate he State or Item	Sic	To per serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to the serior to	Outpatient 3 DOA OTHER:	Home 5 Residence	8 Other (Specify)		
ING PHYSIC After this cer eath with th marked, c	ВУ РНУ	27. MANNER OF DEATH  1 Natural 5 Pending (Month, Dey, Yell Accident Investigation	RY 28b. TIME OF 28 INJURY	c. INJURY AT WORK?	26d. DESCRIBE NOW IF	JURY OCCURED	
L OR ATTENDING F DIRECTOR: After thours after death item 28 is mar	ETED E		URY — At home, ferm, street, factory, Specify)	office	281. LOCATION (Street e City or Town, State)	nd Number or Rural	Route Number,
OR A DIRE hours	PLE	29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my ki	nowledge, death occurred at the time	dete and place, and due	to the council and man	nor no otate d	
HOSPITAL FUNERAL WITHIN 72 H	COMI	one) 2 MEDICAL EXAMINER: On the basis of exemin					s) end manner as stated,
TO THE HOSPIT TO THE FUNERA be filed within 7	TO BE	206 BIGNATURE AND TITLE OF CERTIFIER Calla L. Celexande	0	D27	WBER 087	≥ 4/20	(Mogth, Day, Year)
1		Carla D. Celexander  30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF  CHASE-BREKTON HEATTH	SERVICES 10	01 Cathed	ralst Bo	ulfo 21	201
′		MAY UI 1995	GNATURE	-			



ND 21215-00	nenital or attending
BALTIMORE, MARYLAND 21215-00	av he retained hy the h
BALTIMOR	her death Pane 6 ms
4	within nours at
BOX 6876	tificate be executed with
VITAL RECORDS, P.O. BOX 68760	that the death certi
/ITAL REC	N: The law requires
DIVISION OF VITAL	OR ATTENDING PHYSICIA
	-

use as the burial-transit permit. Pages 1, 2, 3 should physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within thours after death. Page 6 may be retained by the hospital or TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for under within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 28 is marked, or item 23 shows any Interval and Mental Hygiene prior to burial.

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		FOR 1 - STATE REGISTRAR	STATE OF I					HEALTH A		MENTAL HYG	GIENE		
		1. DECEDENT'S NAME (First, Middle, Lest)	. 1				)	Dian.	11	2. DATE OF DEA		YEAR	3. TIME OF DEATH
		ELLEN 4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. In	To		/	T = tener		APRIL	27	95	8 att "
		212-34-9485	1 M 2 X F	6. AGE (In yrs. Ia:	YRS.	MONTHS	DAYS	HOURS :	24 HRS. MIN.	7. DATE OF BIRT (Month, Day, Ye	bar)	Country)	
		9a. FACILITY NAME (If not institution, give str	treet and number)			9b. CIT	ry, TOWN (	OR LOCATIO	ON OF DI	Dec. 2,		Eng]	
1	8 B	Keswick Home				. ]	Balti	imore	1			N/A	
1	ECI	RESIDENCE OF DECEDENT										10d. INSIDE CITY	
1	DIR		N/A			ltim		1014				- 1	LIMITS?
:	AL	10e. STREET AND NUMBER	1/21		Lu.	LULLIE		f. ZIP CODE			10g. CI		AT COUNTRY?
1	FUNERAL	3 York Court						21	218			USA	
li		11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDEN FORCES? 1	NT EVER IN U.S. AF	RMED	13.	. WAS DEC	ENDENT OF	F HISPAN	NIC ORIGIN? (Speci in, Puerto Rican, at	ify Yes or No-		- American Indian, White, etc.
	à l	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE W					2 X NO			·.,	Specify.	
		15. DECEDENT'S EDUC (Specify only highest grade of	CATION	18a. D	ECEDENT'S	USUAL (	OCCUPATIO	ON		16b. KIND C	F BUSINESS/IN	DUSTRY	
i i	بِي	Elementary/Secondary (0-12)	College (1-4 or 5 -	+)	e. Do NOT us	ise retired.)	)	ost of working	g				
13	COMPLETED	9 years		Di	etary	/ Sur	<u>servi</u>				cal Hos		
5	3	17. FATHER'S NAME (First, Middle, Last) Thomas		II						ME (First, Middle, M	laiden Surname)		
	H	111OHAS  19a. INFORMANT'S NAME (Type/Print)		Hugh		ADDRES	es /Strant s		len	Route Number, City o	- Tour Chair 7		ighes
	임	Mr. James J. Nor	ton										and 21218
must be notined at once		20a. METHOD OF DISPOSITION		20b. PLACE	AND DATE (	OF DISPOS	SITION /Na	anne of		DATE 20	ore. M.	- City or Town	n. State
		1 XBurial 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	Ival from State	cemetery, cre New C	athe	dral	Cem	etery	<i>7</i>	4/29 E	Baltimo	re. M	aryland
examiner		21. SIGNATURAL SERVICE LINE	house			22.	. NAME AN	ND ADDRES	S OF FA	CILITY			TL y TITLE
		Martin D. Kav	wson			6	110ne	York	Vied Roa	efeld Ho d, Balti	me imore	MD 21	212
medical		23. PART I. Enter the diseases, or cl shock, or heart failure. L	complications the	it caused the de	eath. Do	not enta	r tha mo	da of dyir	ng, auc	h aa cardiac Dr	raspiratory as	rrant,	Approximata
INC INC		IMMEDIATE CAUSE (Final	march, march										interval Batween Onsat and Daeth
1,		disease or condition resulting in death)	wifer	uncler	oth	c CL	ara	cova	Rev	clar c	linear	le	unkuonen
200			DUE TO	(OR AS A CONSE	OUENCE OF	F):							
NO C	ERTIFICATION	Sequentially list conditions,	DUE TO	(OR AS A CONSE	QUENCE O								-
TAT	\$	if any, leading to immediate cause. Enter UNDERLYING				,							
TIC.		CAUSE (Disease or injury that initiated events	DUE TO	(OR AS A CONSE	OUENCE O	F):							
		resulting in death) LAST	d										
		PART ii. Other significant conditions	a contributing to	death but not	rasulting	in the u	nderlying	g cause g	iven in		AS AN AUTOPSY		VERE AUTOPSY FINDINGS
PHYSICIAN: MEDICAL	ž							2 0			ERFORMED?	0	MAILABLE PRIOR TO COMPLETION OF CAUSE
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3 2	ž	DID TOBACCO USE CONTR	RIBUTE TO CA	USE OF DEA	TH Y	ES 🗆	NO [	UNC	ERTAIN	1 🗆			
	5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	CE OF DEAT	TH (Check							
V	2		1 Inpetient 2			4 X Nur	insing Home		sidence	6 C Other (Specify			
K		1 Natural 5 Pending	28a. DATE OF (Month, De		26b. TIM	JURY M		URY AT PRK? YES 2		28d. DEŞCRIBE H	IOW INJURY OC	CCURED	
S E		3 ☐ Suicide & ☐ Could not be	28a. PLACE C	F INJURY — At ho	ome, farm,	atreat, fac			1	28f. LOCATION (S	irmet and Numbe	er or Rural Rou	ita Mumbar
20 IS	9	4 Homicide 6 Could not be	building,	etc. (Specify)			,	,		City or Town,		W Dr rivers room	NO MUNICON,
COMPLET	1 5	29a. CERTIFIER (Check only	CIAN: To the best of	my knowledge, di	ath occurr	ed at the	time, data	and place,	and dua	to the cause(s) an	d manner as ats	ted	
	5												and manner as atated.
El u	u II	29b. SIGNATURE AND TITLE OF CERTIFIER						29c. LICEN					Month, Day, Year)
	- 11	M. Liabelle was	- gregi	up D				D13	65	7	. 0		27,1995
1 6	- II												

296. SIGNATURE AND TITLE OF CENTIFIER
M. ISABELLE WAS 29c. LICENSE NUMBER D13657 29d. DATE SIGNED (Month, Day, Year)

Depuil 27, 1995 RESIDENCE OF DEATH (ITEM 27) (Typo, Print)

TACGREGOR, KESWICK, 700 W-40 H ST BAUTITORE) (7) 21211

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DIRECTOR: / 28

BALTIMORE, MARYLAND 21215-0020

P.O. BOX 68760

DIVISION OF VITAL RECORDS,

OR ATTENDING PHYSICIAN: The law requires that

HOSPITAL FUNERAL Within 72 1 IMPORTANT: If

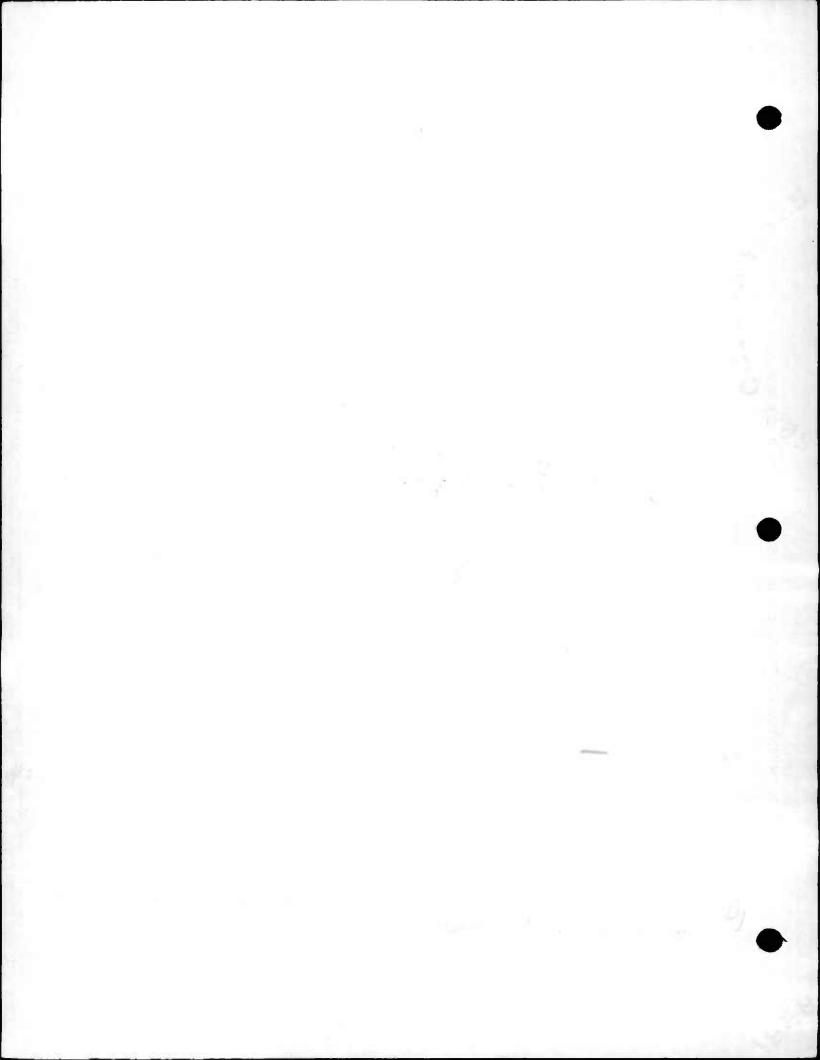
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within an hours after death. Page 6 may be retained by	been signed by the attending physician and completely filled in by the funeral dire	
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH HENRY NAGEL 1995 В. APRIL 26 3:23 Am 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign Country) 220-38-9743 DAYS HOURS TOWN 2 F 53 January 12, 1942 Maryland 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 415 belt STREET BALTIMORE CITY N/A RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD N/A Baltimore City 1-XXES 2 NO FUNERAL 10a STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 1415 Belt Street 21230 U.S.A 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES ※ NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puerto Rican, stc.)

1 YES XXXIVO Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black. White, atc. 1 🔀 Mover Married 2 🗌 Married IF YES, GIVE WAR OR DATES B 3 Widowed 4 Divorced White BE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 12th CocaCola Company N/A Line Leader 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) John J. Nagel Agnes H. Savina 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Margaret Bowman 1510 Battery Avenue, Baltimore, MD 21230 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 1 SC Sprial 2 Cremation 3 Ramoval from State
4 Donation 8 Other (Specify) cemetery, cramatory or other r cem., April 29.1995 Maryland 21. SIGNATURE OF FUE ERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Charles L. Stevens Funeral Home, 1501 E. Fort Avenue, Baltimore 21230 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximata shock, or heart failure. List only one cause on each Interval Between IMMEDIATE CAUSE (Final Onset and Daath disease or condition resulting in death) CARDIAC ARRHYTHMIA DUE TO (OR AS A CONSEQUENCE OF): MEDICAL CERTIFICATION Sequentially list conditions DUE TO (OR AS A CONSEQUENCE OF): If any, laading to immediata cause. Entar UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algorithment conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 TYES 2-NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 X YES 2 | NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) 28s. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK7 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide determined 29a. CERTIFIER 1 _ CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE APRIL 26,1995 O.C.M.E. 9 IPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201



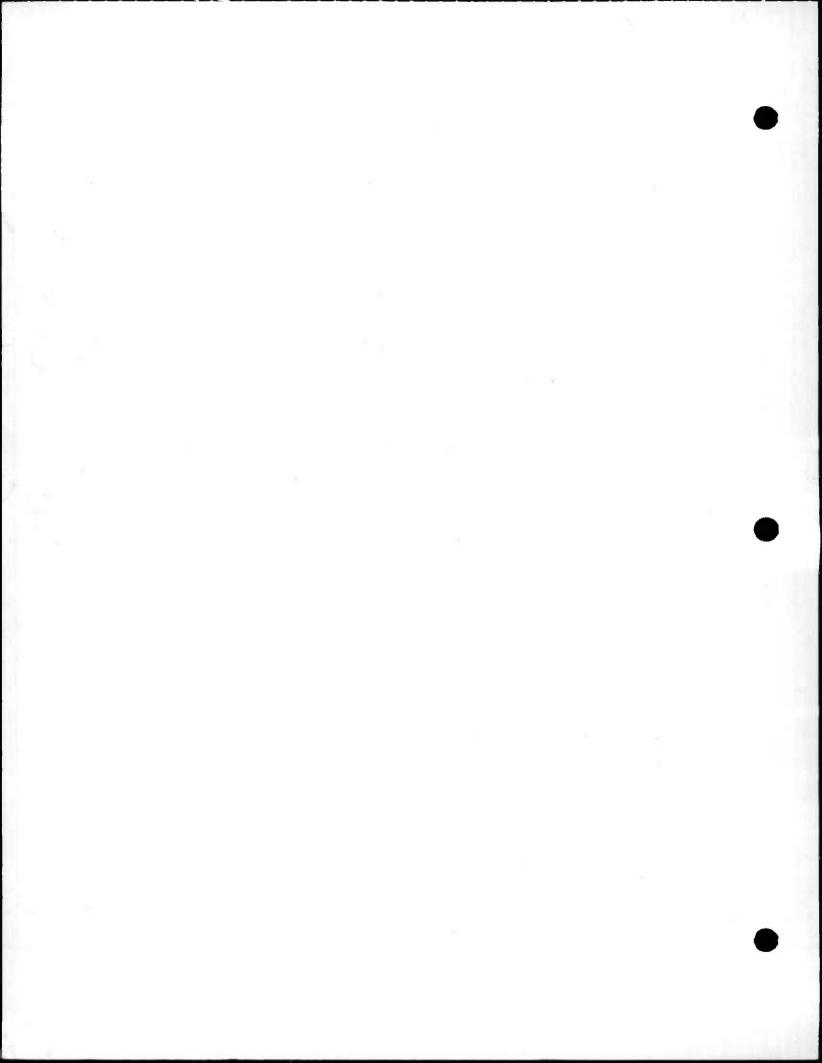
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2X hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	-ICATE C	F DEATH	RE	G. NO.		
1	1. DECEDENT'S NAME (First, Middle, Last)		41		-	2. DATE OF DI	EATH DAY	YEAR	3. TIME OF DEATH
j	IRVIN	/	VOEDIN			4	29	95	15 Ep 11
	4. SOCIAL SECURITY NUMBER		GE (In yrs. last birthday)			7. DATE OF BIL		8. BIRTI	HPLACE (State or Foreign
9	215-14-4041		13 YRS.	MONTHS DA	S HOURS MIN.	(Month, Day,		MA	RYLAND
1	90. FACILITY NAME (If not institution, give st PTT-ANTIC GENER 9733 HEALTH WAY RESIDENCE OF DECEDENT	reet and number)	1	96. CITY, TO	N OR LOCATION OF D			INTY OF C	
R	9733 HEALTHWAY	Deive.		BCR	LIN		Wol	ece	ster
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DIRECTOR	10a. STATE 10b. COUNTY			TY, TOWN OR LO					10d. INSIDE CITY LIMITS?
	MARYLAND BAL	timore		ANSE	owne				1 TYES 2 NO
₹	too. STREET AND NUMBER				101. ZIP CODE				WHAT COUNTRY?
<u> </u>	108 FIRST Ave	wie			2122	7		1,5	, A.
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVE FORCES? 1 Y	R IN U.S. ARMED		DECENDENT OF HISPA			14. RAC	E American Indian, k, White, etc.
BY.	t Never Married 2 Merried  3 Widowed 4 Divorced	IF YES, GIVE WAR OF			epecify Cuben, Mexic (ES 2 NO Speci		atc.)	Spec	the °
									White
TED	15. DECEDENT'S EDUC (Specify only highest grade	ATION completed)	16e. DECEDENT'S	work done during	ATION most of working	16b. KIND	OF BUSINESS/IN	DUSTRY	
7	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT			100	ostru.	+	INN
COMPLET	12		IIIA	NAGE					
8	17. FATHER'S NAME (First, Middle, Last)	, ,				AME (First, Middle,			
BE	ALBERT NOR	0/0				IAN S			
2	19e. INFORMANT'S NAME (Type/Print)	1			et and Number or Rural				
- 1	PATRICIA NORDI	iN .	/08	FIRS	t Aven	oc LA	NSDOWN	s, m	0.21227
	20e. METHOD OF DISPOSITION t ☐ Burlel 2 Cremetion 3 ☐ Remo	wei from State	20b. PLACE AND DATE	OF DISPOSITION	(Name of	DATE	20c. LOCATION —	City or To	own, State
- 1	4 🗆 Donetion 5 🗆 Other (Specify)	TOTAL STATE	cemetery, crematory or	Remat	DRY	571	CATONS	16/1/6	MD.
- 1	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	)	00 01000					
		> _	-0	7719	HAM MAND	GERRY R	d BALTI	norc.	MD, ZIZZ7
	22 DADT ( Enter the discourse		J-01						
	23. PART . Enter the diseases, or c ehock, or heert failure. I	lst only one ceuee or	nad tha death. Do n eech line.	not enter tha	mode of dying, suc	ch as cardiec p	r reapiratory ar	rast,	Approximate Intervel Between
	IMMEDIATE CAUSE (Final								Onset and Death
	diseese or condition resulting in deeth)	ASC	210						EW YES
- 1		DUE TO (OR A	S A CONSEQUENCE	OF):					
2	Sequentially liet conditions.	),							
Ĕ	If any, leading to immediate	DUE TO (OR A	S A CONSEQUENCE (	NF):					
CERTIFICATION	CAUSE (Disease or injury								
Ë	thet initiated evants resulting in death) LAST	DUE TO (OR A	S A CONSEDUENCE (	OF):					
H H		l,							
	PART II. Other eignificent conditions	contributing to deeti	but not reculting	In the underi	ing cause given in	Pert I 24a	WAS AN AUTOPSY	246	. WERE AUTOPSY FINDINGS
EDICAL			-		and and all the		PERFORMED?	1 ***	AVAILABLE PRIOR TO COMPLETION OF CAUSE
						1 🛭	YES 2 NO		OF DEATH?
Σ									1 - YES 2 - NO
PHYSICIAN:	DID TOBACCO USE CONTR	IBUTE TO CAUSE				N 🗆 📗			
ᅙ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF DEA	OTHER:	ne)				
<u>ı</u> ₹	1 YES 2 NO	1 Inputient 2 KER/O	sutpatient 3 🗆 DOA		ome 5 🗆 Reeldence	6 Other (Spec	cify)		
표Ⅱ	27. MANNER OF DEATH	28e. DATE OF INJUR (Month, Day, Year	r) 28b. Til	AE OF 28c.	INJURY AT WORK?	28d. DESCRIBE	HOW INJURY OC	CURED	
B	t Natural 5 Pending 2 Accident Investigation				YES 2 NO				
	3 Suicide 8 Could not be	26e. PLACE OF INJU building, etc. (S	IRY — At home, term,	street, tectory, o	ffice	28t. LOCATION City or Town	(Street and Number	or Rural I	Route Number,
	4 Homicide determined		,,,			City or low!	n, State)		
COMPLETED	29e. CERTIFIER	CIAN: To the best of my kn	owledge death occur	and at the time	ate and alone and du	to the course of			
\$ 1		R: On the beels of exemina							\d
8									
H	29b. SIGNATURE AND TITLE OF CERTIFIER	710 41	mx		29c. LICENSE NU		29d. DAT	E SIGNED	(Month, Day, Yeer)
ှု	Wotothy Ci	agoouls.	111.01		906	241		4-	79-95
- 1	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF	DEATH (ITEM 27) (Type	e, Print)			~	.,	hel
	DOROTHY	C, MOLZU	IORTH	20	3 SNOW	37.	SNOW,	HILL	ND. 21863
	MAY 01 1995	32. ATGISTRAS S	NATURE						
W	MAY OT 1333	. 50							



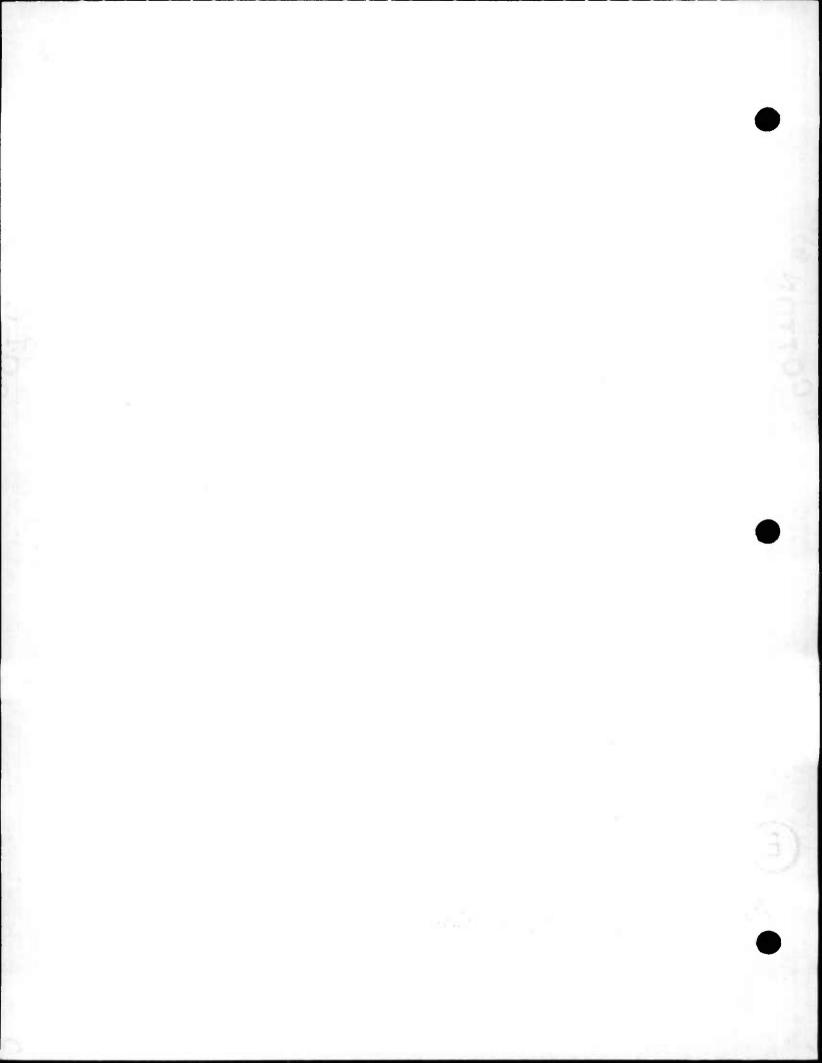
**BALTIMORE, MARYLAND 21215-0020** 

IIVISION OF VITAL RECORDS, P.O. BOX 68760

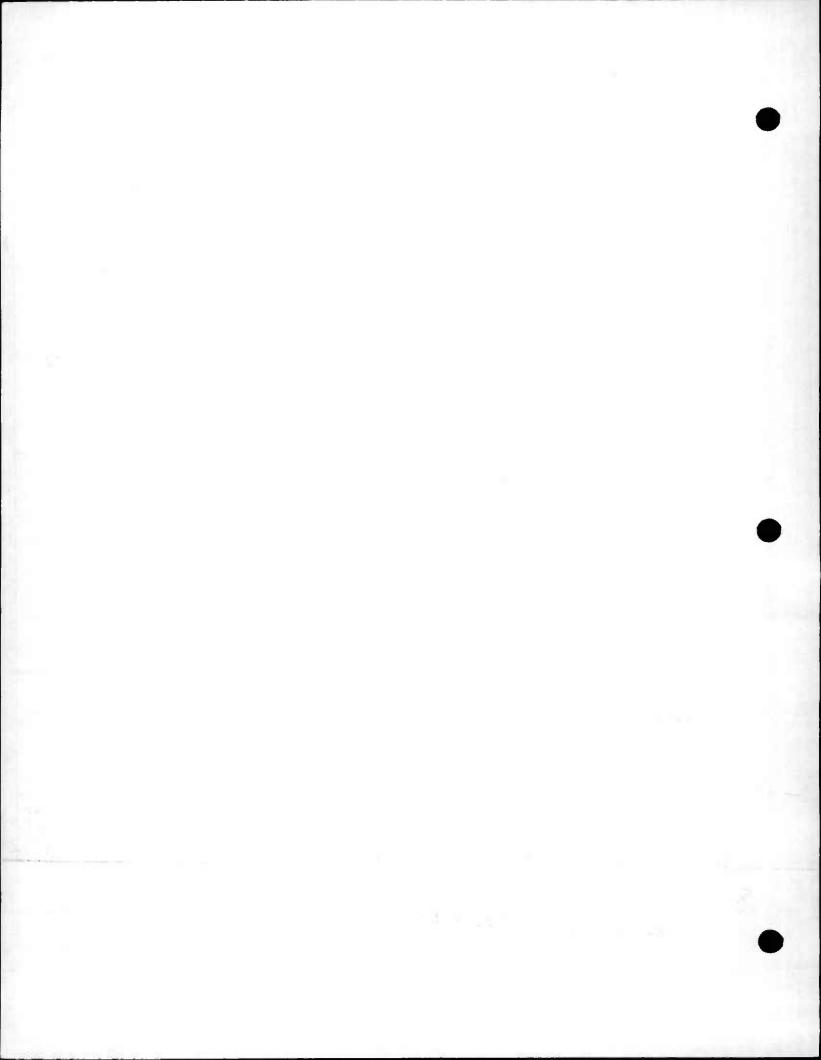
TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of the form of

FOR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE OF MA	RYLAND / DEPARTMENT OF CERTIFICATE OF		HYGIENE REG. NO.	
	1. DECEDENT'S NAME (First, Middle, Last)  Anna B. Nau		2. DATE MONTH		3. TIME OF DEATH
	215-10-8607 1 DM 2 DSF	AGE (In yrs. lest birthdey)  105  YRS.  F UNDER 1 YEAR  MONTHS  DAYS	HOURS MIN. Oct.	, Day, Year) Coul	rhPLACE (State or Foreign nary) lanyLand
TOR	98. FACILITY NAME (If not institution, give street and number)  Menidian Penning Pank RESIDENCE OF DECEDENT		or location of death	9c. COUNTY OF Bal	timore.
DIRECTOR	Md. N/A	10c. CITY, TOWN OR LOC Baltima			10d. INSIDE CITY LIMITS? 1 XYES 2 NO
FUNERAL	100. STREET AND NUMBER 4520 E. N. Charles	St.	101. ZIP CODE 2/2/0	10g. CITIZEN OF	WHAT COUNTRY?
BY FU	11. MARITAL STATUS  1 1 Never Merried 2 Merried  3 Widowed 4 Divorced  12. WAS DECEDENT IF FORCES? 1 IF YES, GIVE WAF	YES 2 NO It yes,	ECENDENT OF HISPANIC ORIGIN specify Cuban, Mexican, Puerto R ES 20 NO Specify:	licen, atc.) Bia	CE — American Indian, ock, White, etc.
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	16e. DECEDENT'S USUAL OCCUPA (Give kind of work done during i life. Do NOT use retired.)	most of working	KIND OF BUSINESS/INDUSTRY	
COMP	17. FATHER'S NAME (First, Middle, Last)	Accountant	16. MOTHER'S NAME (First, M	_	Bondinglo
TO BE	Charles Nau 19. INFORMANT'S NAME (TyposPrint) Melvin F. Kaufman	19b. MAILING ADDRESS (Street	Banbana tend Number or Rurel Route Numb eenn Ave. Ba	er, City or Town, State, Zip Code)	2/4
	20e. METHOD OF DISPOSITION  1	20b. PLACE AND DATE OF DISPOSITION ( competery, gramatous or other place)  \$\text{TOLU} Redeemen\$	Name of DATE	20c. LOCATION — City or	Town, State
TO BE COM	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		AND ADDRESS OF FACILITY  They Miller  Thanford R		ome Le, Md. 21234
	23. PART I. Enter the disease, or complications that connects, or heart failure. Liet only one cause IMMEDIATE CAUSE (Finel disease or condition resulting in death)  DUE TO (0.000)	aused the deeth. Do not enter the n on each line.	ode of dying, such as card	lec or reepiratory arrest,	Approximate
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury	R AS A CONSEQUENCE OF):	9000		7
MEDICAL C	PART II. Other significent conditions contributing to de	oeth but not resulting in the underlying the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the culture of the cultur	ng ceuse given in Part I.	24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
AN: M	DID TOBACCO USE CONTRIBUTE TO CAU 25. WAS CASE REFERRED TO MEDICAL	SE OF DEATH YES NO			1 TYES 2 THO
PHYSICIAN:	27. MANNER OF DEATH 280. DATE OF IN	JURY 28b. TIME OF 28c. II	ome 5 Residence 6 Other	(Specify) CRIBE HOW INJURY OCCURED	
à	1 Natural 5 Pending (Month, Day. 2 Accident Investigation 3 Suicide 8 Could not be (Month, Day.	NJURY — At home, term, street, tectory, of	VORK7 YES 2 NO	TION (Street end Number or Rural	Route Number,
COMPLETED	4 Homicide determined  29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my	knowledge, death occurred at the time, da	te end place, end dua to the caus		
8	2 MEDICAL EXAMINER: On the basic of example 29b. SIGNATURE AND TITLE OF CERTIFIER	Ination end/or investigation, in my opinion,	death occured at the time, date		(e) end menner ee stated.  D (Manth, Day, Year)
τ0	8903 Daidfor	OF DEATH (ITEM 27) (Typg: Print)	altimo	te md.	
	MAY U 1 1995 Julia Maria				



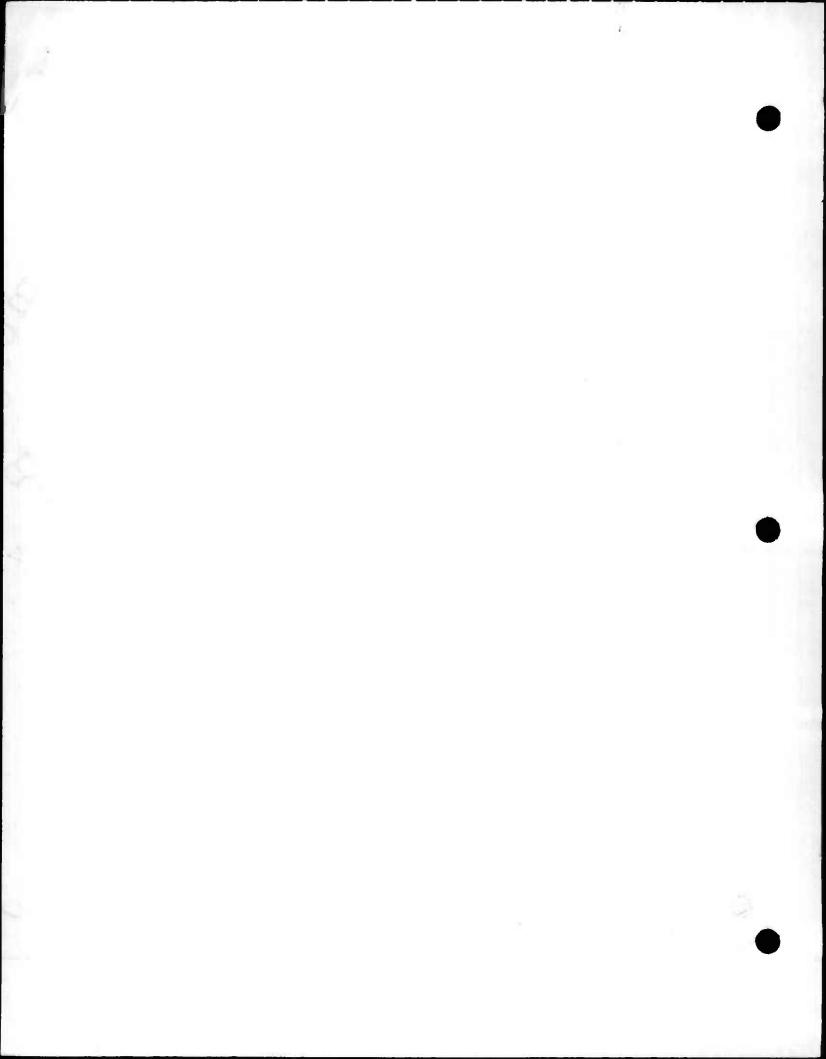
	FOR										9:		13156	
	1 - STATE REGISTRAR		STATE OF N	IARYLANI	D / DEPAI CERTIF	RTMENT (	OF DEA	H AND I	MENTAL	HYGIEN REG. NO.				
	1. DECEDENT'S NAME (First, Midd CLIFFORD	SNIVE	LY		PILL	ING			2. DATE O	DA		YEAR	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 215-09-8954	1.7	. SEX		. lest birthday)	IF UNDER 1 Y	EAR IF UND	ER 24 HRS.	APRII 7. DATE O	E BIRTH		995 a. BIRTH	2:29 IPLACE (State or Foreign)	p M gn
	9a. FACILITY NAME (If not institution		M 2 F	78	YRS.		OWN OR LOCAL	1 -124		Day 1'55', 1		Mar	yland	
O.B.	GREATER BALTI	MORE		CENTE	'R	TOWSO		TION OF DE	AIH			NTY OF D		
DIRECTOR	RESIDENCE OF DECEDE  10e. STATE 10b.	COUNTY			10c. CIT	Y, TOWN OR I		-			DALLI	INOR	10d. INSIDE CITY	
		Baltim	ore Co.		Par	rkvill	e						LIMITS?	<b>.</b>
FUNERAL	3349 Acton Ro	ad					101. ZIP CO				10g. CIT		VHAT COUNTRY?	
BY	11. MARITAL STATUS 1 Never Married 2 Merri 3 Widowed 4 Divorced		2. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2	NO	If y	S DECENDENT es, specify Cub	en, Mexica	n, Puarto Rk	(Specify Yee can, etc.)	or No—	Black	E — American Indian, k, While, stc.	
TED	15. DECEDEN (Specify only high	T'S EDUCAT	ION mplated)	16e.	DECEDENT'S	work done duri	JPATION ing most of work	king	16b. I	CIND OF BUS	INESS/INC	DUSTRY		
COMPLETED	Elementary/Secondary (0-12)	(	College (1-4 or 5+	)	Machin					Gas M	lachi	nist		
BE CON	17. FATHER'S NAME (First, Middle, Albert Edward		ing				18. MO E. ]	THER'S NAI	ME (First, Mid Sniv	ddie, Meiden /ely	Sumeme)			
TO B	190. INFORMANT'S NAME (Typo/Pr Mrs. Ruth N.		ng		3349	Acton	Road	or or Aural F Parkv	ille,	City or Town	n, State, Zic	212	34	
	20e, METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 4 Donation 5 Other (Spec	Ramova	I from Stale	20b. PLA	CEAND DATE	of disposition	tery	5-01	-95		KV11		wn, State ary land	
	21. SIGNATURE OF FUNERAL SEF	PVICE LICEN	Jeffr	ey L.	Gair	le	ME AND ADDR	J. Ru	ick, I					
	23. PART / Erfecthe dispass shock, or heart iMMEDIATE CAUSE (Final disease or condition resulting in death)	ranure. Lis	Pneumo	nia	death. Do i	not enter the	a mode of d	ying, such	n as cerdis	KAIT.	more	est,	Approximete interval Betwood Onset and D	reen
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	6 d			SEQUENCE O									
MEDICAL O	PART II. Other algolificent co			death but no	ot resulting	in the under	riying ceuse	given in i		PERFOR	MED?	24b.	WERE AUTOPSY FINDI AMAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH?	
ME	DID TODA CCO LICE	COLUMN AND IN	1177 70 044							^			1 (X YES 2 NO	
PHYSICIAN:	DID TOBACCO USE C		UIE IO CAL		LACE OF DEA			CERTAIN	1 🗆 ]					
Sic	EXAMINER?		OSPITAL: Xinpatient 2 -	ER/Outpatient	3 DOA	OTHER:	Home 5 🗆 R	teeldence	6 🗆 Other (	Specify)				$\neg$
	27. MANNER OF DEATH  1 Netural 5 Pendi	ng	28e. DATE OF I	NJURY y, Year)	28b. TIM	URY	c. INJURY AT WORK?		28d. DESCI	RIBE HOW IN	JURY OCC	URED	-	$\neg$
) BY	2 Outolds	igation I not be	28a. PLACE OF	INJURY - AI	home, farm,		Office	∐ NO	28f. LOCAT	ION (Street &	nd Number	or Rural R	oute Number,	$\dashv$
E	4 Homicide determ		autiong, e	ic. (Specify)					City or	Town, State)				
COMPLETED			N: To the best of a										and manner as state	d.
8	296. SIGNATURE AND TITLE OF C		Pele	lm	mt	)	29c. LIC	27740	BER		29d. DATE		(Month, Day, Year)	
5	30. NAME AND ADDRESS OF PERS											1		$\dashv$
	Robert A. Pal 31. DATE FILED (Month, Day, Year)	/	M.D	GBMC	6701 N	Char	les St	reet,	Balt	imore	MD	2120	4	
	MAY 01 1995	5 Jul	az. EGISTIAN	N. P. CO.	246									



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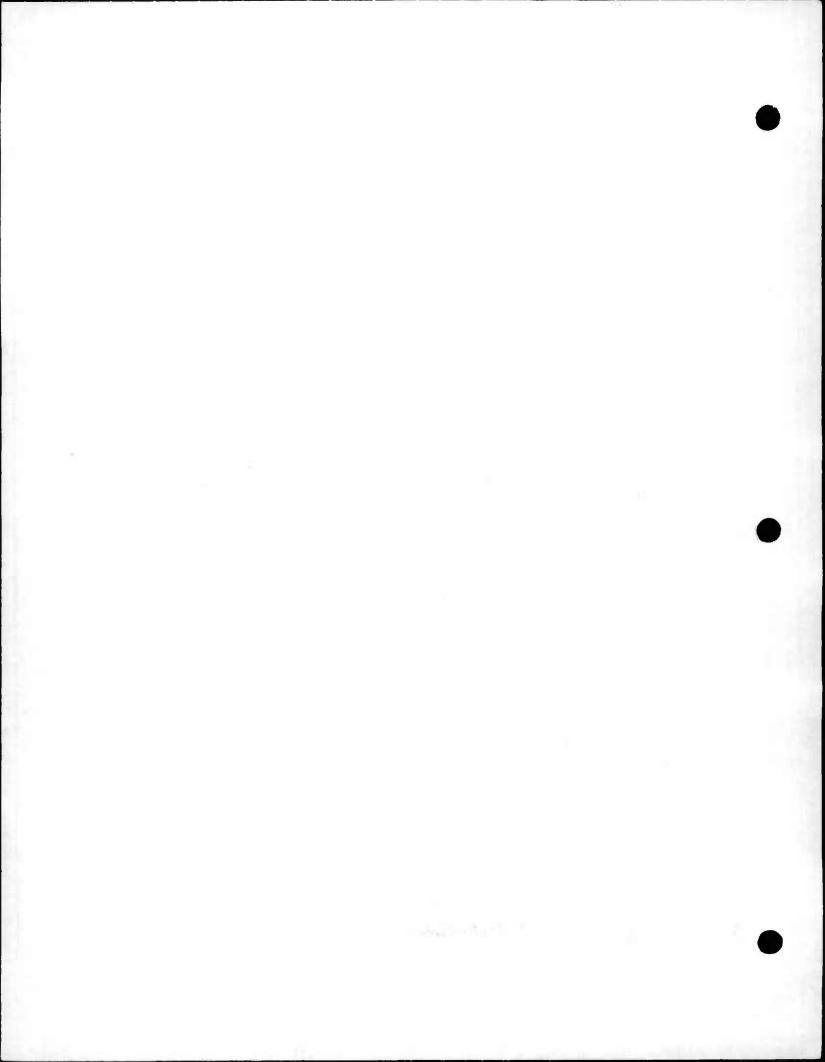
			1 - STATE REGISTRAR	STATE OF MARYL	AND / DI	EPARTMI TIFICA	ENT OF I	HEALTH AND	MENTA	L HYGIENI REG. NO.	E		,	
			1. DECEDENT'S NAME (First, Middle, Last) Elva R. Powe						MON1	E OF DEATH		AR	TIME OF DEA	TH
			4. SOCIAL SECURITY NUMBER		(In yrs. last bir	tholau) IE II	NDER 1 YEAR	IF UNDER 24 HRS.	<del></del>	ril 22			:30	P
pino	pino		169-50-9350  9e. FACILITY NAME (If not institution, give	1□ M 2 😾 F 1		YRS. MONT	THS DAYS	HOURS MIN.	Feb	o. 25,1		enn:		
	2, 3 should	N.	Citizens Nursi					de Gra			Hari			
		CL	RESIDENCE OF DECEDENT  10e. STATE 10b. COUNT	TV .		O. OUTY TO	WN OR LOCA	71011					MODELLE CONTRACT	
	permit. Pages 1,	DIRECTOR	Maryland Har	ford			st H	ill					LIMITS?	
	ansit per	FUNERAL	1906 Monford D	rive			10	21050			U . S	OF WHAT	COUNTRY?	
BALTIMORE, MARYLAND 21215-0020 or death. Page 6 may be retained by the hospital or attending physician. The funeral director, page 5 should be detached for use as the burial-transit	å [	BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 K NO		If yes, s	CENDENT OF HISPA pecify Cuben, Mexic S 2 NO Specif	en, Puerto		or No 14.	Specify:	American Ind	lien,
215	use as	E	15. DECEDENT'S EDU (Specify only highest grade		(Give A	and of work a	L OCCUPATI	ON ost of working	16	b. KIND OF BUS	INESS/INDUST	_		
ND 21		PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	IIIe. Do	NOT use retir	ed.)			YT -				
ANI Re hos	detached for once.	COMPLET	17. FATHER'S NAME (First, Middle, Last)		[ НО	usew	ire	18. MOTHER'S NA	AME (First.		ome Sumeme)			_
YL I by th	8 %	ш	David Barlett							leman				
MARYLA e retained by the	5 should notified	10 B	19a. INFORMANT'S NAME (Type/Print) Patricia Butle	r	19b. M 215	Rec	kord	end Number or Rural Rd. Fa	Aoute Num	ton, M	D 210	947		
BALTIMORE, after death. Page 6 may be y the funeral director, page noval.	tor, page		20a METHOD OF DISPOSITION 1 Buriel 2 Commention 3 Rem	noval from State	petery, cremate	DATE OF DIS	POSITION (N	ery 4/2	C / O	1	CATION — City		State	
P30 e	ner m		21. SIGNATURE OF FUNERAL SERVICE LI	CEMBER	1		22. NAME A	ND ADDRESS OF FA	CILITY		.go, I			
ALT death.			( Mut 2	mydeen	elle			dzinski						22.
200	alcal		23. PART i. Enter the diseasea, Dr	complications that cause	d the death	. Do not a	nter tha mo	Old Ea	ch aa car	diac or reapir	atory arrest,	- • p 1 ^M 1	Approxim	
ili es ho	ompletely hilled in it, cremation, or r event, the me		iMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cause on e		mul	M	MESIDO	nT				interval 8 Onaat an	
760 ed with	even	CERTIFICATION	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	DUE TO (OR AS	CONSEQUE	NCE OF):		11501146						V
executed and con	sician and con prior to burial, traumatic e		Sequentially liet conditions, if any, leading to immediate	b. DUE TO (OR AS A	CONSEQUE	NCE OF:	> 1	71701196						
ate be			ceuse. Enter UNDERLYING	couse. Enter UNDERLYING CAUSE (Disease or injury										
. 9	Hygiene or other	HE I	that initieted events resulting in death) LAST	DUE TO (OR AS A	CONSEQUE	NCE OF):								
dea .	The attending Mental Hygie njury, or ot			d										
that	282	MEDICAL	PART II. Other algnificant condition	ne contributing to death b	out not reeu	iting in the	underlyin	g cause given in	Part i.	24s. WAS AN A PERFORI 1 YES 2	MED?	AVA	RE AUTOPSY F FLABLE PRIOR MPLETION DF DEATH?	TO OT
F 5	been signed t. of Health a shows any		DID TOBACCO USE CONT	DIDLITE TO CALLSE O	E DEATH	VEC F	T NO F	T UNICEDTAL	N 158			1 [	YES 2 🔀	NO
A è	Sa Dept	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	KIBOTE TO CAUSE C	26. PLACE O				N A					
IAN: T	ne State	SIC	EXAMINER?  1 TES 2 TO NO	HOSPITAL: 1   Inpetient 2   ER/Outs	patient 3 🗆 I		HER: Nursing Hon	ne 5 🗆 Reeldence	6 🗆 Othe	er (Specify)				
PHYSICIAN:	with th		27. MANNER OF DEATH  1 X Natural 5 Pending	26e. DATE OF INJURY (Month, Day, Year)	28	b. TIME OF INJURY	W	JURY AT ORK? YES 2 NO	28d. DE	SCRIBE HOW IN	JURY OCCURE	D		
	4 6 m	ED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home,	ferm, atreet,	fectory, offic	20		CATION (Street er or Town, State)	nd Number or R	ural Route	Number,	
- 8	E SE	LETEI	29e. CERTIFIER 1 52 CERTIFYING PHYS	ICIAN: To the beat of my know	lades death	annumed at 1	he time date			Street				
SPITAL	TO THE FUNERAL DE filed within 72 ha	COMPL		ER: On the beele of examination								use(e) end	l menner ee s	etated.
# HOS	M with	ш	296. SIGNATURE AND THE OF CENTIFIE			_		29c. LICENSE NU			29d. DATE SIG			
5	E Se	TO B	30. NAME AND ADDRESS OF PERSON WI	AO COMBI ETED CAUGE OF DE				D 4641	2		<b>&gt;</b> 4	12.	+19:	<u> </u>
4			540 41N	319	s. u			Havre	de	Grace	, MD.	21	078	
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		1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / D CEF	EPARTME RTIFICA	NT OF H	EALTH AND DEATH		YGIENE REG. NO.			
	1	1. DECEDENT'S NAME (First, Middle, Lest)						2. DATE OF MONTH	DEATH DAY	YEAR	3. TIME OF C	DEATH
		ANNA NINA  4. SOCIAL SECURITY NUMBER	RILEY  5. SEX 8. AGE					APRIL	29	1995	7:37	
pino		219-10-8073  96. FACILITY NAME (If not institution, give st	1 □ M 2 🎇 F	68	YRS. MONTH		IF UNDER 24 HRS. HOURS MIN.	JAN. 2	6,192	6 BA	TIMORE	Foreign MD
, 3 should	E .	ST. AGNES HOSPITA			90.0	ITY, TOWN D	BALTIM			BALTIMO		rv
1. 2,	20	RESIDENCE OF DECEDENT  10s. STATE 10b. COUNTY			0c. CITY, TOW					DINETIN		
permit. Pages	DIRE	MARYLAND	BALTIMOR			NSDOW					10d. INSIDE ( LIMITS? 1 YES 2	
	3AL	10e. STREET AND NUMBER					ZIP CODE			10g. CITIZEN DF		-
020 physician. burlai-transit	FUNER	2969 BERO ROAD	10 Mac December Cure				212				5.A.	
	B	1 Never Married 2 X Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR DR	2 X NO		if yes, spe 1 TYES	enDENT OF HISPA city Cuben, Mexic 2 ND Speci	an, Puerto Rice	pecify Yes o n, etc.)	No.— 14. RAC Blac Spec	E — American I k, Whits, etc. ily: WHITE	
r attending use as the	TED	15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)	16a. DECED	DENT'S USUAL	OCCUPATIO	N t of working	16b. KIN	ID OF BUSIN	NESS/INDUSTRY		
	COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do	OMEMAI	1.)	•	-	ш	OMEMAKTI	īC.	
The hos detach	OM	17. FATHER'S NAME (First, Middle, Last)		1 11	OTILITIA	LLIK	18. MOTHER'S NA	ME (First, Midd			NG .	
AYL d by the beat dat	BE C	DANIEL PELLIGRINI					VIRGIN			NOWN)		
MARYLAND retained by the hospit 5 should be detached notified at once.	0	19a. INFORMANT'S NAME (Type/Print) MR. DAVID RILEY					Mumber or Rural					
AE, nay be page		20g. METHOD OF DISPOSITION	20	b. PLACE ANO			AD - LA	DATE		21227 ATION — City or To		
MOR ge 6 ma irector, p		t X Burist 2 Cremsiton 3 Remo 4 Donation 5 Other (Specify)	val from Stats	LOUDON				5/2		ALTIMORI		
BALTIMORE, MARYLAND after death. Page 6 may be retained by the hospit by the funeral director, page 5 should be detached moval. cal examiner must be notified at once.		21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE	4	i i	2. NAME AN	D ADDRESS OF FA D FUNER.	AL HOMI	E. TNO	C.		
BAI the fu the fu oval.		Jocpie M	Shar	mo	4	107 W	ILKENS .	AVENUE-	-BALT	IMORE, N	D 212	29
hours ed in the		23. PARTÚ. Enter the diseases, pr ci shock, pr heart fallure. L IMMEDIATE CAUSE (Final	ist only one ceuse on	each line.			le of dying, suc	ch as cerdiec	Dr respira	tory arrest,		imate Between and Death
_ >= =		disease or condition resulting in death)		cute MI.					24	lione		
P 2 2 2 2	_		DUE TO (OR AS	CONSEQUE	NCE OF):						148	ani
OX 68 e be execut sician and c infor to burit traumatic	TIO	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUE	NCE OF):							
Co to Se P	FICA	CAUSE (Disease or injury	DUE TO (OR AS	PD	NOS OF						72	any
P.O. B th certificat tending phy al Hygiene p or other	CERTIFICATION	that initiated events resulting in death) LAST	D 10	isel	O						IYe	ars.
Ge at de de de de de de de de de de de de de		PART II. Other aignificant conditions	contributing to death	but not recu	iting in the	undadulaa	gerree share to	Post I or			1-1	
m - 5 = -	MEDICAL		Anaemia.			Part I. 24a. WAS AN AUTOPSY PERFORMED?			AWAILABLE PRIOR TO COMPLETION OF CAUSE			
AL RECOF he law requires that has been signed to Dept. of Health a	MEC								_ TES 2 [[_	, NO	DF DEATH?	) ND
AL R he taw re has bee popt. m 23 sl		DID TOBACCO USE CONTR	IBUTE TO CAUSE (		_		UNCERTAI	N D				
- F 8 8 5	PHYSICIAN:		HOSPITAL: 1   Inpatient 2   ER/Out		F DEATH (Che	ER:						
. 0 55	H	27. MANNER OF DEATH	28s. OATE OF INJURY (Month, Day, Year)		b. TIME OF	28c. INJU WOR	5 Residence			URY OCCURED		
ON OF DING PHYSI After this c death with	BY	1 Netural 5 Pending 2 Accident investigation			м	I 🗆 YI	S 2 ND					
TTEND TTEND TTOR: A after d	ETED	3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			281. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
SPITAL DR A VERAL DIREC NN 72 hours VT: If Item	COMPLE		IAN: To the best of my know: On the basis of examination								) and manner a	s stated.
TO THE HOSPITAL C TO THE FUNERAL D be filed within 72 ho IMPORTANT: If IN	BE	296. SIGNATURE AND TITLE OF CERTIFIER	low				29c. LICENSE NUI			PAPRIL		
F F Q E	2		IMAD S	ALE	(Type, Print)	57	PAGN	AGNES HOSP-ER				
6		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S GIGI	VATURE								
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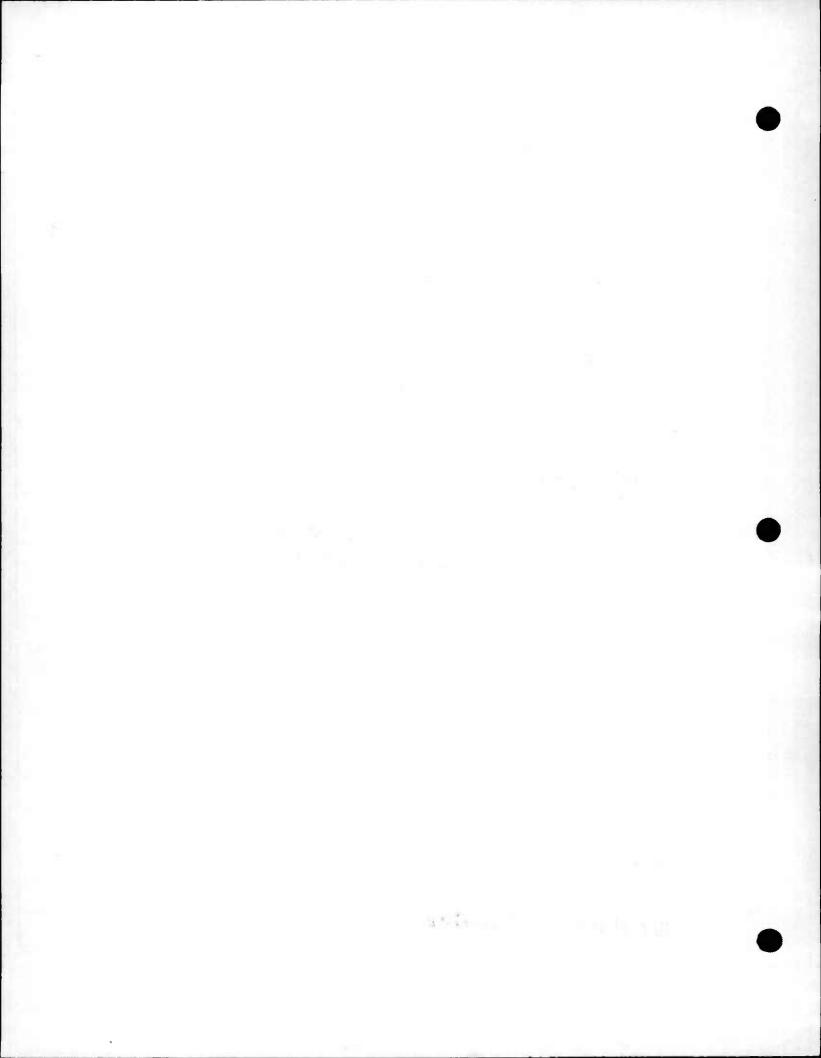
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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR Herman 28. ROGERS April 1995 5:18 a M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. OATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 1 M 2 - F DAYS HOURS 216203643 66 DEC 15, 1928 MARYLAND Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR FRANKLIN SQUARE HOSPITAL ROSSVILLE Baltimore County 10e. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY  $M\Box$ BALTIMORE hours after death. Page 6 may be retained by the hospital or attending physician. of in by the funeral director, page 5 should be detached for use as the burial-transit permit. ROSEDALE 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY 7910 DAKDALE AVENUE 21237 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, While, etc. 1 Never Merried 2 Merried Specify WHITE В 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KINO OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) EXECUTIVE TRUCKING 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) BE NHOL ROGERS IDA notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 7910 OAKOALE AVENUE ROSEOALE, MO 21237 SHIRLEY ROGERS ě 20s_METHOD OF DISPOSITION
14 Burlel 2 Cremetion 3 Removal from State
4 Donation 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must DATE GARDENS OF FATTH BALTIMORE, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE 21237 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, filled in by Approximate ehock, or heert feilure. List only one ceuse on each ilne interval Between IMMEDIATE CAUSE (Final **Onset and Death** cremation, disease or condition MYOCARDIAL INFARCTION and completely fi to burial, crematio ACUTE resulting in deeth) event, CARDIOVASCULAR DISEAST HTHEROSCLEROTIC 104051 traumatic CERTIFICATION Sequentially list conditions, 9 DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate physician prior cause. Enter UNDERLYING CAUSE (Diseese or injury other signed by the attending phy Health and Mental Hygiene DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST 5 PART il. Other algnificent conditione contributing to deeth but not resulting in the underlying cause given in Pert i. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24e. WAS AN AUTOPSY PERFORMED? DIDEMIA any 1 ☐ YES 2 📉 NO OF DEATH? shows 1 YES 2 NO t, of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN CIAN Dept. S has 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Rem State HOSPITAL: OTHER: PHYSI 1 YES 2 X NO 1 № Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 0 the the 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Yeer) 28b. TIME OF INJURY 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED marked. this with 1 X Natural 5 Pending Investigation м 1 YES 2 NO BY death 2 Accident After 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: A hours after of COMPLETED 8 Could not be 28 4 Homicide Item 29e. CERTIFIER (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Check only (Ch 8 TO THE HOSPITAL
TO THE FUNERAL (
De filed within 72 h
IMPORTANT; If II 2 MEDICAL EXAMINER; On the beele of exa imination end/or investigation, in my opinion, death occured at the time, date end piece, end due to the cause(e) end menner se stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Ybert 띪 29c LICENSE NUMBER Lacheromany W15022 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (LTEM 27) (Type, Print) RD., BALTA. PHILADELPHIA Ms 21237 MAY 01 1995 32 REGISTRAR'S

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

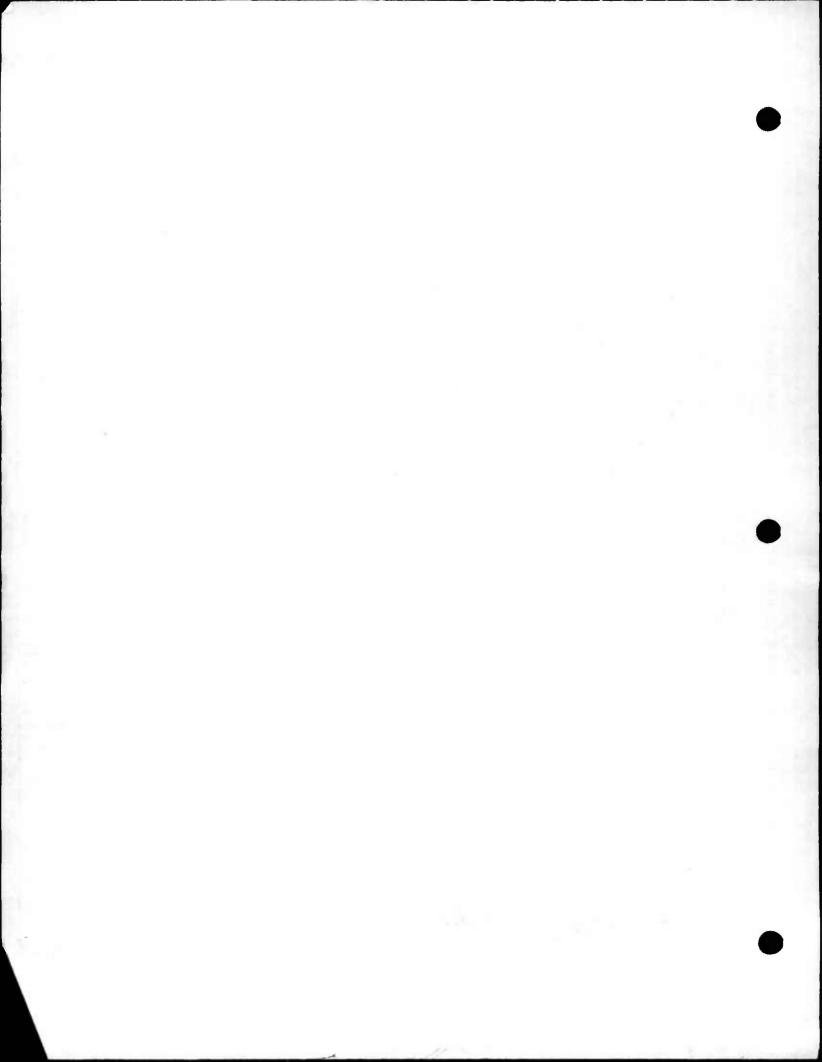


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CERTIFICATE OF DEATH REG. NO DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH SORRELL ALICE APRIL 0815 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year)
Aug ust 2 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 1984 1 M 2 M F HOURS Pages 1, 2, 3 should 9b. CITY, TOWILOR LOCATION OF DEATH OC. COUNTY OF DEATH DIRECTOR Vorthwes 200 RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10b. COUNT 10d. INSIDE CITY 201 1 VES 2 NO detached for use as the burial-transit permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2806 21216 U.S.A Drive 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or Noafter death. Page 6 may be retained by the hospital or attending physician. by the funeral director, page 5 should be detached for use as the burial-tran 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AMMEO FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. If yea, specify Cuban, 2 Married Black BY Specify: 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) once. 17. FATHER'S NAME (First, Middle, Last 16. MOTHER'S NAME (First, Middle ornellus BE notified 19a. INFORMANT'S NAME (TypyPrint) 2 2806 Ba Ellicott Dr. md 1216 Wan (40, å 20e. METHOD OF OISPOSITION

PG Surial 2 Cremation 3 Removal from State 20b, PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must Arbutu 5 Other (Specify) item 23 shows any injury, or other traumatic event, the medical examiner 21 SIGNATI FWNERAL SERVICE LICENSEE 22 NAME AND ADDRESS OF FACILITY 4 300 Jabash 23. PART i. Enter the disea es, Dr complications that caused the death. Do not anter the mode of dying, such as cardisc or respiratory streat, allure. List only one cause on each line. filled in by Approximate hock, or hear interval Betwe cremation, or IMMEDIATE CAUSE (Final **Onset and Death** 11 ROSEPSIS disease or condition_ completely 2 DAYS resulting in death) DUE TO (OR AS A CONSEQUENCE OF): burial. CERTIFICATION and Sequentially list conditions, QUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to if any, leading to immediata cause. Enter UNDERLYING physician CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initisted events resulting in death) LAST attending Mental Health and Men PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? HYPERTENSION 1 YES 2 THO 1 TES 2 NO t. of F DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h HOSPITAL: 1 YES 2 NO estlant 2 - ER/Outpatiant 3 - DOA 4 Nursing Home 5 Realdence 8 Other (Specify) marked, or 鲁 27. MANNER OF DEATH 28c. INJURY AT WORK? 28a. DATE OF INJURY (Month, Day, Year) 28d. DESCRIBE HOW INJURY OCCURED with t 1 Natural 1 YES 2 NO BY death 2 Accident 3 Suicide 28 15 28a. PLACE OF INJURY — At he building, etc. (Specify) 281. LOCATION (Street and Number or Flural Floute Number, City or Town, State) MAPLETED DIRECTOR appe 4 🔲 Homicide E FUNERAL DIRECT of within 72 hours a MEMORALI Item 2 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) NER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and pieca, and due to the cause(a) and manner as stated. 29c. LICENSE NUMBER D 3 7 3 五 年 著 SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Vear) ► APRIL 25, 9) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NHC 32/ ESISTEMS PLANETES

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Ilem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	EALTH AND	MENTAL	HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) JESSE	SOLOMON					F DEATH DAY	3. TIME OF OEATH  8:35 A M			
	4. SOCIAL SECURITY NUMBER 099-05-4396	1 💢 M 2 🗆 F		F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, SEPT		Count	NPLACE (State or Foreign		
TOR	98. FACILITY NAME (If not institution, give s ST. AGNES HOSPITA RESIDENCE OF DECEDENT		S		R LOCATION OF D IMORE	EATN	9c. CO	9c. COUNTY OF DEATH  BALTIMORE CITY			
DIRECTOR	10e. STATE 10b. COUNTY MARYLAND	BALTIMORE	10c. CITY, TOWN OR LOCATION BALTIMORE					10d. INSIDE CITY LIMITS? 1 YES 2 NO			
IERAL	100. STREET AND NUMBER 319 CHALFONTE DRI	VE		10t. ZIP CODE 21228					10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 12 YES IF YES, GIVE WAR OR D. WW	R IN U.S. ARMED  13. WAS DECENDENT OF HISP ES 2 NO 11 yes, specify Cuban, Max 1  YES 2 NO Spe			ican, Puerto Rican, atc.)			I. RACE — American Indian, Black, Whita, atc. Specify: WHITE		
TO BE COMPLETED	15. DECEOENT'S EDU( (Specify only highest grade Elementary/Secondary (0-12)	CATION completed)  Coffege (1-4 or 5+)  4 YRS	16a, DECEDENT'S US (Give kind of wor life. Do NOT use if	k done during mo: retired.)	t of working	16b, KIND OF BUSINESS/INDUSTR					
	17. FATHER'S NAME (First, Middle, Last) HYMAN SOLOMON	, 110	COIN OTHE	TROOM	18. MOTNER'S NA	AME (First, Mid YANO	UNKNOW Idle, Meiden Surname) WITZ	/IN			
	190. INFORMANT'S NAME (Type/Print) MRS. PAULINE SOLO		319 CH	ALFONTE	DRIVE -		City or Town, State, Z IMORE, MI		1228		
	29. METHOD OF DISPOSITION DIPORT 2 Cremation 3 Remote 4 Donation 8 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LIC	oval from State Cem	PLACE AND DATE OF etery, crematory or othe ELLWOOD C	EMETERY	O ADDRESS OF FA	4/30	120110 201	WN AND,	N . W .		
	23. PART / Enter the diseases, Dr c	l. Shan		4107 W	D FUNERA	VENUE	,, MD. 21	229			
	shock, or heart feilure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)	a	NEU MO		e or aying, suc	n as cerdie	C Dr reapiratory a	rreat,	Approximata Interval Batween Onset and Death  Approximata		
PHYSICIAN: MEDICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  OUE TO (OR AS A CONSEQUENCE OF):										
	ALZHE MERIS DISEASE  PERFORMED?  1 YES 2 06  AMILIABLE PRIOR TO COMPLETION OF CALL OF DEATH?  1 YES 2 106  1 YES 2 106								^/		
ICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH		UNCERTAI	N 28					
	1 YES 2 NO  27. MANNER OF DEATN  1 Netural 5 Pending	1 Inpatient 2 ER/Outp 28e. DATE OF INJURY (Month, Day, Year)	atlent 3 DOA 4	3 DOA 4 Nursing Home 5 Residence  28b. TIME OF NURSING WORK?  M 1 YES 2 NO			9 6 □ Other (Specify)  28d. OE\$CRIBE NOW INJURY OCCURED				
TED BY	2 Accident Investigation 3 Suictde 6 Could not be 4 Nomicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, stre				28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
COMPLETED	28e. CERTIFIER (Check only one)  2 MEDICAL EXAMINER: On the basis of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as atsted.  2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as atsted.										
TO BE C	246 SIGNATURE AND TITLE OF CERTIFIER	MEATAL	RESI	1739	29c. LICENSE NUI	89	) 29d. DA	FRIZ	(Month, Day, Year)		
	30. NAME AND ADDRESS OF PERSON WING	HABOB	ATN (ITEM 27) (Type, Pri	CAFC	en t	Ive,	BACIL	KOX:	EMD2122		
	MAY 0 1 1995	3. REGISTRAR'S SIGNA	Karlett,								

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BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3 should

permit.

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the hours after death. Page 6 may be retained by the hospital or attending pl	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the by be filled within 72 hours after death with the State Debt, of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the be filed within 72 hours after death with the State Dept, of Health and M.	IMPORTANT: If item 28 is marked, or item 23 shows any inju

2

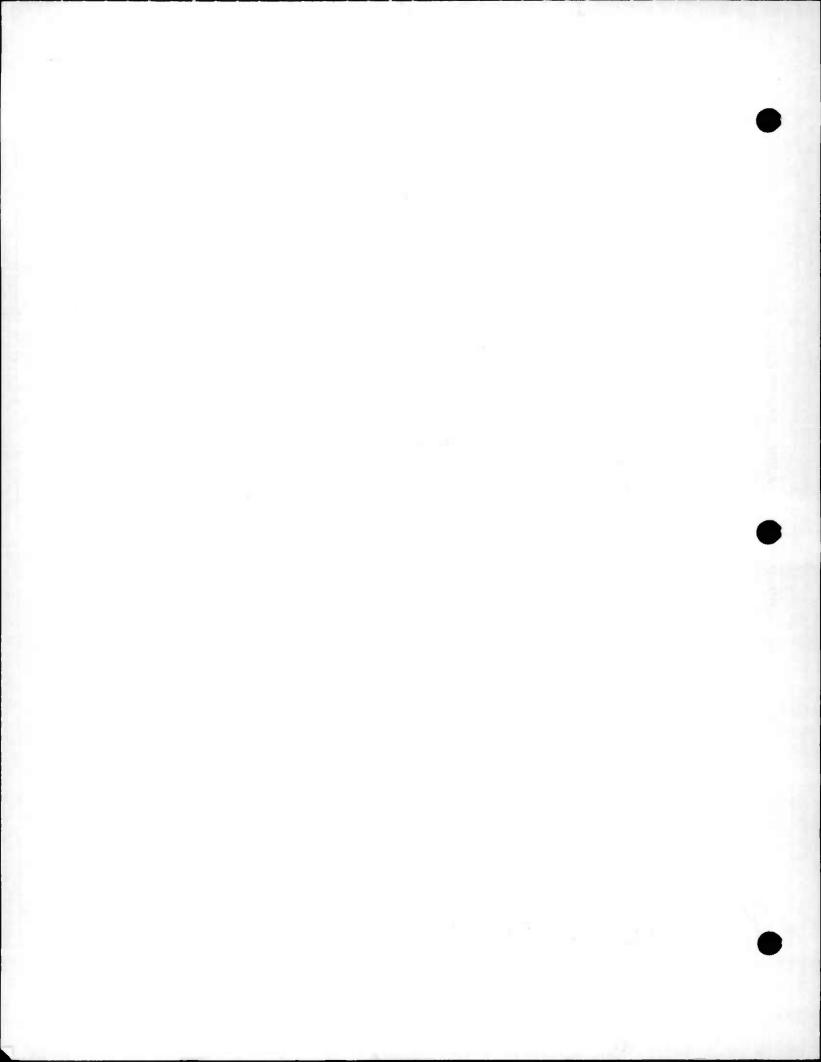
95 13162 FilmG 723. item #20a, 20b 5/4/95.cyw, perf.h. FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH APRIL 28, 1995 HENRY PAUL SIMONET 8:55 P 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign Country) IF UNDER 24 HRS. DAYS HOURS 1 X M 2 F 213-01-5155 86 YRS. LePIZOU, FRANCE AUG. 23,1908 Se. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR SUMMIT NURSING HOME BALTIMORE BALTIMORE RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND BALTIMORE BALTIMORE 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5931 SUNSET AVENUE 21207 U.S.A 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, OIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried 1 TYES 2 NO BY 3 Widowed 4 Divorced Specify: WW II WHITE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16. DECEDENT'S USUAL OCCUPATION 16b, KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 8 +) A.A.DEGREE LAUNDRY SUPERVISOR FULTON LAUNDRY Once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Melden Surname) notified at UNKNOWN BE GERMAINE (UNKNOWN) 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 MRS. PHYLLIS A. FITZPATRICK 5931 SUNSET AVENUE - BALTIMORE, MD 21207 8 20e. METHOD OF DISPOSITION

Burlel 2 🗵 Cremetion 3 🗆 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must NEG CATHEDERAL CEMETERY 5/3/ 4 Donation 8 Other (Specify) BALTIMORE examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229 medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, Approximata ahock, or heart failure. List only one cause on each line. Interval Between **IMMEDIATE CAUSE (Final** Onset and Daath the our disease or condition_ Che her vosulor reaulting in death) event. DUE TO (OR AS A CONSEQUENCE OF): ser tendin other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 5 injury, PART II. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMAII ARLE PRIOR TO shows any COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ PHYSICIAN: item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) 1 TES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 6 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28 is marked, 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident 5 Pending 1 YES 2 NO BY Investigation 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, etc. (Specify) 261, LOCATION (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be COMPLETED 4 Homicide 29e. CERTIFIER (Check only one) 1 SCERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(e) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 1 / Com m. 34951

DR. EDMUND P. TKACZUK - 405 FREDERICK ROAD - SUITE 100 - Catonsville Md 21228 31. DATE FILED (Month, Day, Year) Lin Studior Reveal

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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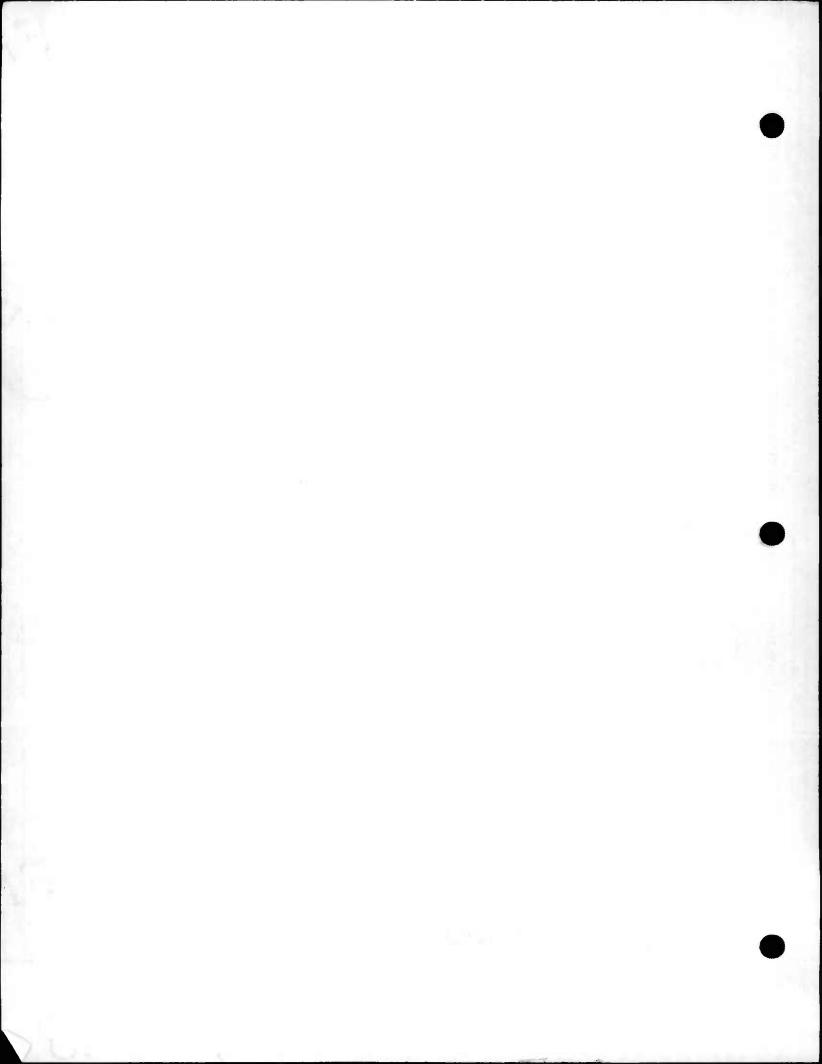
TO BE COMPLETED BY FUNERAL DIRECTOR	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
al examiner must be notified at once.	APORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should oval.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.
fler death. Page 6 may be retained by the hospital or attending physician.	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

									95	13163
	1 - FOR STATE REGISTRAR	STATE OF M		DEPARTME				HYGIENE REG. NO.		
8	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE O		VEA	3. TIME OF DEATH
	JOHN WILLS			ERRY			APRI	L 28,	1995	1:40A. M
	4. SOCIAL SECURITY NUMBER 215-12-9542	1 🖾 M 2 🗆 F	6. AGE (In yrs. les	t birthday) IF UI YRS. MONT	HB DAYS	IF UNDER 24 H	M. (Month,	BIRTH Day, Year) 11/20	Co	PITHPLACE (State or Foreign suntry) IARYLAND
TOR	9a. FACILITY NAME (If not institution, give sti  MANOR CARE TOWSO  RESIDENCE OF DECEDENT			9b. 0		OWSON	OF DEATH	•	ec. COUNTY O	LTIMORE
DIRECTOR	10a. STATE 10b. COUNTY	rimore		10c. CITY, TOW		TION				10d. INSIDE CITY LIMITS?
7	10e. STREET AND NUMBER	LIPORE		LOWS		f. ZIP CODE			IGa. CITIZEN C	1 YES 2 NO
BY FUNERAL	1302 ABLETT ROAD	12. WAS DECEDENT	FVFR IN U.S. AD	MED		21239	SPANIC ORIGIN?		Ü	JSA
	1 Never Married 2 K Married 3 Widowed 4 Divorced	FORCES? 1 ( IF YES, GIVE WA	YES 2 A	10	If yes, sp	ecify Cuban, Ma 3 2 X NO S	exican, Puerto Ric	can, etc.)	8	ACE — American Indian, llack, White, atc. pecity: WHITE
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade : Elementary/Secondary (0-12)	CATION conquisited) College (1-4 or 5 +)	(G)	CEDENT'S USUA No kind of work of Do NOT use retin	one during mo		16b. F	UND OF BUSIN	EBS/INDUSTR	Υ
COMP	12th GRADE 17. FATHER'S NAME (First, Michille, Laut)		F	OOD PUR	CHASE	-	S NAME (First, Mi	RESTAU		
TO BE	TRA B. SPERRY 194. INFORMANT'S NAME (TyposPrint)		190	. MAILING ADDI	NESS (Strout )	A STREET, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUARE, SQUA	RENCE B	AND DESCRIPTION OF THE PERSON NAMED IN	The Person Name of Street, or other Designation of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Person of the Per	,
۲	DORIS M. SPERRY			1302 AE	I.ETT	ROAD	TOWSON.	MD 2	1239	
	20s. METHOD OF DISPOSITION  1 fig Burial 2 C Cremation 3 Please 4 Donation 5 C Other (Specify)	wel from State	20b. PLACE A cemetery, cres	MEDIATE OF DIS MINORY OF OTHER PARTIES	POSITION /N	ame of	5/1/95	29c. LOGA	TIMORE	
ĺ	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE	TINEN			NO ADDRESS O		I DAL	TIPORE	MD
	1/1/1				8521	LOCH R	ERAL HO	VD T	OWSON.	MD 21286
	23. PAST. Enter the diseases, or caheck, or heart feiture. I IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Liat only ona caus	caused the date on each line.							Approximate interval Between Opset and Death
TION	Sequentially list conditions, if any, leading to immediate	DUE TO (	OR AS A CONSEC	DUENCE OF):			(2)	net	ato 7.	ic .
RTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (	OR AS A CONSEC	DUENCE OF):						
CERT	resulting in death) LAST	J								
PHYSICIAN: MEDICAL	PART II. Other eignificant conditions	a contributing to c	leath but not n	esulting in the	undariyin	g cause giver		4a. WAS AN AU PERFORME	ED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 - NO
ICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		ОТІ	26. PI	ACE OF DEATH	(Check only one)			
PHYS	1 YES 2 WNO  27. MANNER OF DEATH	26e. DATE OF II	NJURY		Nursing Horr 28c, INJ		28d. DESC	Specify) RIBE HOW INJU	JRY OCCURED	)
ED BY	1	28e. PLACE OF building, e	INJURY — At hor	me, ferm, street,	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	YES 2 NO	281. LOCAT	ION (Street end Town, State)	Number or Rui	ral Route Number,
COMPLET	29a. CERTIFIER (Check only									
8	one) 2 MEDICAL EXAMINER	4: On the besie of exa	amination end/or is	nvestigation, in r	my opinion, d	leath occured at	t the time, date a	nd place, and d	lue to the caus	se(e) end manner ee stated.
BE	29b. SIGNATURE AND TITLE OF CENTIFIER	un V	no			29c. LICENSE	NUMBER 128	3	9d. DATE SIGN	NED (Month, Day, Year)
임	30 NAME AND ADDRESS OF PERSON WHO	COMPLETED CALIF	OF DEATH OFFI	1000			, , ,		- 10	

D327 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 7401 Osler Drive Suite 206 Towson, MD
32 REGISTRAR'S SIGNATURE

Joseph Adams, 31. DATE FILED (Month, Day, Year) MD MAY 01 1995

DHMH-18 Rev 1/89



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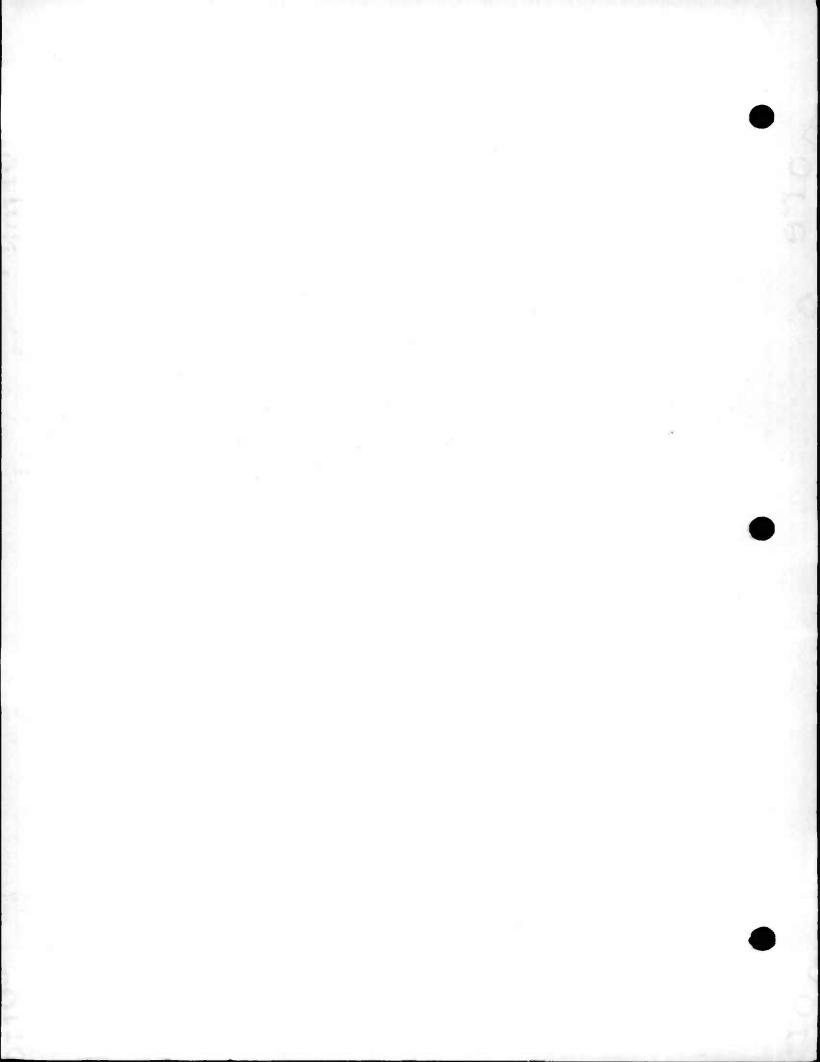
DIVISION OF VITAL RECORDS, P.O. BOX 6876

ed with nours after death. Page 6 may be retained by the hospital or attending physician.	3 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should if the within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	nd, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with rouns after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic e	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

MAY 01 1995

						95	13164
	1 - FOR STATE OF MARYLAND A		RTMENT OF H		MENTAL HYGIEN	_	
	1. DECEDENT'S NAME (First, Middle, Last)  4. SOCIAL SECURITY NUMBER  5. SEX  6. AGE (In yrs. le.		IF UNDER 1 YEAR	IF UNDER 24 HRS.	2, DATE OF DEATH		YEAR 995 / 50 A M  8. BIRTHPLACE (State or Foreign
	215-10-4036 10M2×F 83	YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) JUNC 15,19	911	Country) MARYLAND
TOR	9e. FACILITY NAME (If not institution, give street and number) SAINT ENIZABOTHS HOME 900 CATON AUCNUC RESIDENCE OF DECEDENT			A LOCATION OF DE		9c. COUN	N/A
L DIRECTOR	10e. STATE  10b. COUNTY  MARYLAND  BALTIMORE  10e. STREET AND NUMBER		Y, TOWN OR LOCAT	100%			10d, INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	3928 Benson Avenue			ZIP CODE	7		ZEN OF WHAT COUNTRY?
BY	11. MARITAL STATUS  1 Never Merried 2 Merried  3 Widowed 4 Divorced  12. WAS DECEDENT EVER IN U.S. AI FORCES? 1 YES 2 WIFYES, GIVE WAR OR DATES		If yes, spe		IIC ORIGIN? (Specify Yen, Puerto Ricen, etc.)	e or No-	14. RACE — American Indien, Black, Whita, atc. Specify; *
COMPLETED	(Specify only highest grade completed)  [(College (1-4 or 5 +)	live kind of t . Do NOT u	USUAL OCCUPATION Work done during most retired.)	st of working	OWN F		USTRY
	17. FATHER'S NAME (First, Middle, Last) STOPHON S. HORDOCK				ME (First, Middle, Malden	Surname)	
TO BE	19a. INFORMANT'S NAME (Type/Print) 15	b. MAILING	BENSON	nd Number or Rural I	Route Number, City or Tox	n, State, Zip	Code) LAND 21227
	1  Suriat 2 Cremation 3 Removal from State cemetery, cn 4 Donetion 5 Other (Specify)		OF DISPOSITION (Na. other place)				City or Town, State  ( , MARYLAND
	21. SIGNATUSE OF EUNERAL BERVICE LIQUISES	D.	22. NAME AN PAYM B & /3285	DADDRESS OF FA	NERAL HOI DRING-ROAD	nc. BALTI	MORE, MARYLAND 21227
	21 PART 1. Enter the disesses, or complications that caused the dishock, or heart fellura. List only one cause on each line immediate CAUSE (Final disease or condition resulting in death)	. ti	C	da of dying, such	1 1	$\cap$	est, Approximata Interval Batween Oneat and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	QUENCE O	Nelli	lus /	tui		
IEDICAL	PART II. Other significant conditions contributing to death but not	resulting	In the undarlying	cause givan in	Part I. 24a. WAS AN PERFO	RMER?	24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
SICIAN: M	DID TOBACCO USE CONTRIBUTE TO CAU 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  HOSPITAL:	SE OF		ES NO			1
품	1 Pes 2 NO 1 Inpetient 2 ER/Outpetient 3  27. MANNER OF DEATH  1. Natural 3 Pending	28b. TIM	4 Nursing Home IE OP 28c. tNJI JURY WO	URY AT	8 Other (Specify) 28d. DESCRIBE HOW	INJURY OCC	CUREO
TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined 28s. PLACE OF INJURY — At he building, etc. (Specify)	oma, ferm,			281. LOCATION (Street City or Town, State	and Number	or Rural Route Number,
COMPLET	29a. CERTIFIER (Check only one)  2   NEDICAL EXAMINER: On the basis of examination and/or						
TO BE C	29b. SIGNATURE AND THILE OF CENTIFIER			29c. LIGENSE NUM	ABER 5626	29d. DATE	SIGN (Month, Den Year)
	38. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITE	1 4 m	Jy 3	320	bensun?	Ave	1-14up=122

DHMH-16 Rev 1/89



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cremation, or

prior to burial,

en signed by the attending physician and of Health and Mental Hygiene prior to buri

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After death

State Dept.

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for use as the burial-transit permit, Pages 1, 2, 3 should

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6	that
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ΙY	The
DIVISION OF VITAL RECORDS, P.O. BOX 68760	OR ATTENDING PHYSICIAN: The law
VISION	ATTENDING
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	PITAL C

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH DAY 3. TIME OF DEATH Stankowski YEAR anes 1:15 95 AM 4 22 4. SOCIAL SECURITY NUMBER 6. AGE (in yrs. lest birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH 212-09-7166 DAYS HOURS MIN MARYLAND 1 M 2 X F 80 10/14 9a. FACILITY NAME (If not institution, give street and number) 9h CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Hospital Mercy Hos DIRECTOR Baltimore NA 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore 1 YES 2 NO FUNERAL 10a. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 2124 St Fleet 2123 US 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yea, specify Cuban, Maxican, Puarto Rican, atc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 HO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Maxican, Puarto Rid 1 YES 2 X NO Specify: 1 Never Married 2 Married ¥ Specify 3 Widowed 4 Divorced WHITE 18a. DECEDENT'S USUAL OCCUPATION

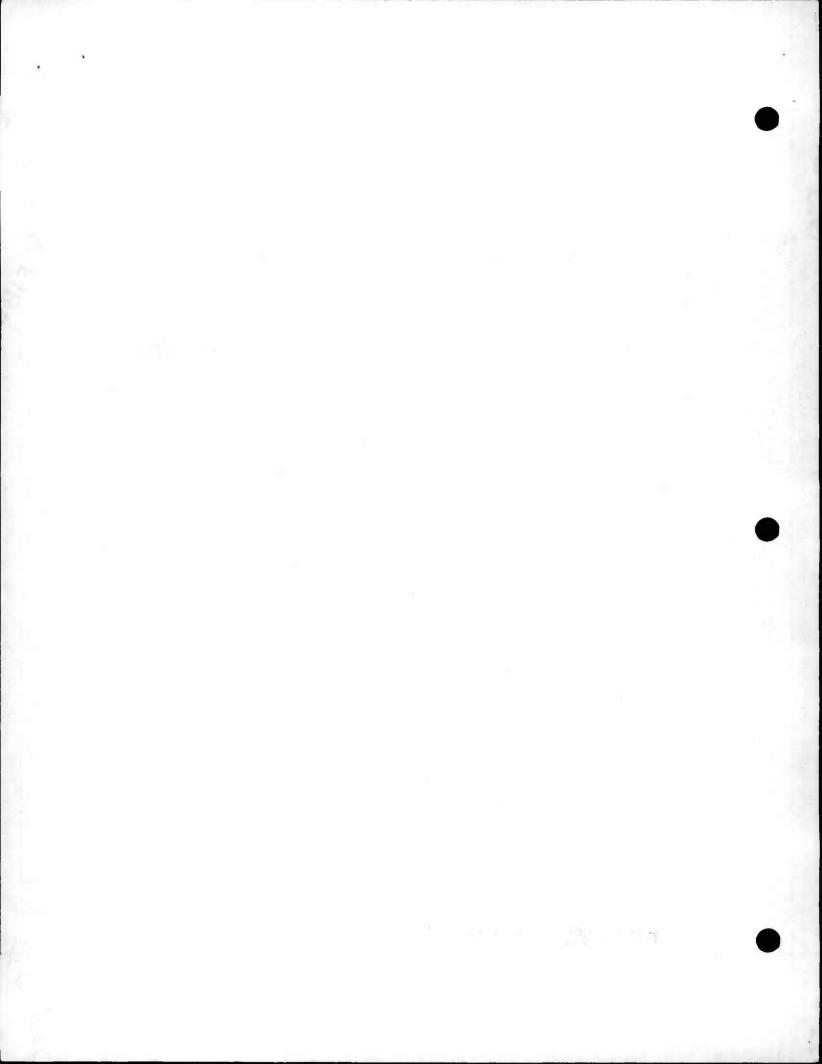
Working most of working most of working COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) YEARS HOMEMAKER OWD 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surnam notified at JOHN KOWALEWSKI BE ( CATHERINE WALTERS 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MS. FRANCES DONAHOO FLEET ST. BALTO. 21231 MD. be 20a, METHOD OF DISPOSITION

1 🔯 Burlal 2 🗆 Cremation 3 🗎 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must TULLY RUSARY CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 4-26 BALTO. CO. MD. traumatic event, the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY KACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTO. 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such ee cerdiac or reepiratory street, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death IMMEDIATE CAUSE (Fine) disease or condition Sepsis resulting in death) 1 days DUE TO (OR AS A CONSEQUENCE OF): Transmural bacteremia 14 days CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate cause. Enter UNDERLYING Mesenteric CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): thet initieted events resulting in death) LAST PART II. Other significent conditions contributing to death but not recuiting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE Coronary artery disease shows any 1 - YES 2 1 NO OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES X NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item HOSPITAL:
1 % Inpatient 2 - ER/Outpatient 3 - DOA OTHER: 1 YES 2 NO ng Home 5 - Rasidenca 6 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED marked, 1 X Natural 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) DIRECTOR: Af hours after de-item 28 is n 3 Sulcide 281: LOCATION (Street and Number or Rural Route Number, 8 Could not be determined COMPLETED 4 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTE be filed within 72 hours at IMPORTANT: If Item 29 29s. CERTIFIER (Check only one)

2 MEDICAL EXAMINER: On the basis of aramination and/or investigation in the course at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 8 Mille Kny MD 122/95 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Bonnie Ridge Dr. Apt T-2 6818 Molly Buzdon Raltimore, MD 21209

31. DATE FILED (Month, Day, Year)

12. REGISTRAN'S SIGNATURE



ITEM: 1. PER F.H. FILM G-723 5/1/95 t.t FOR STATE STATE STATE OF MARYLAND / DE

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STATE	0F	MA	RYI	AND	1	<b>DEPARTMENT</b>	0F	HEALT

ST. AGNES HOSPITAL  RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY  MARYLAND  10c. STREET AND NUMBER  3300 BENSON AVENUE APT. 329  11. MARITAL STATUS  1 Never Married 2 Merried  3 Kindowed 4 Divorced  12. WAS DECEDENT EVER IN U.S. ARMED  15 PORCES? 1 VES 2 X NO  16 DECEDENT'S EDUCATION  (Specify only highest grade completed)  15. DECEDENT'S EDUCATION  (Specify only highest grade completed)  16. DECEDENT'S USUAL OCCUPATION  (Specify only highest grade completed)  17. FATHER'S NAME (First, Middle, Lest)  JOHN JAMES GROSS  SARAH ROUSBY	Specify: BLACK
217-24-7281  30. FACILITY NAME (If not institution, give street end number)  ST. AGNES HOSPITAL  PRESIDENCE OF DECEDENT  100. STATE  100. STATE  100. STATE  100. STREET AND NUMBER  3300 BENSON AVENUE APT. 329  11. MARITAL STATUS  1 Over Married  2 Merried  3 (I) (Widowed 4 Divorced  15. DECEDENT'S EDUCATION  (Specify only highest grade completed)  15. DECEDENT'S EDUCATION  (Specify only highest grade completed)  100. STATE PROVIDER  101. STATE  102. CITY, TOWN OR LOCATION OF DEATH  BALTIMORE  103. STATE  104. CITY, TOWN OR LOCATION  BALTIMORE  105. CITY, TOWN OR LOCATION  BALTIMORE  106. CITY, TOWN OR LOCATION  BALTIMORE  107. ZIP CODE  11. MARITAL STATUS  12. WAS DECEMBENT EVER IN U.S. ARMED  13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Vee or No-  14. YES 2X XNO  15. DECEMBENT'S EDUCATION  (Specify only highest grade completed)  15. DECEMBENT'S EDUCATION  (Specify only highest grade completed)  16. KIND OF BUSINESS/IN  16. MOTNER'S NAME (First, Middie, Meiden Surmame)  17. FATHER'S NAME (First, Middie, Meiden Surmame)  JOHN JAMES GROSS	COUNTY OF DEATH  10d. INSIDE CITY LIMITS?  XX YES 2   CITIZEN OF WHAT COUNTRY?  ITED STATES  14. RACE — American India Black, White, etc.  Specify: BLACK
ST. AGNES HOSPITAL  RESIDENCE OF DECEDENT  10e. STATE  10b. COUNTY  MARYLAND  10c. CITY, TOWN OR LOCATION OF DEATH  MARYLAND  10c. CITY, TOWN OR LOCATION  BALTIMORE  10f. CITY  10e. STATE  10b. COUNTY  MARYLAND  10c. CITY, TOWN OR LOCATION  BALTIMORE  10f. ZIP CODE  10f. ZIP CODE  11. MARITAL STATUS  11. MARITAL STATUS  11. MARITAL STATUS  11. MARITAL STATUS  11. MOVER Merried  3 XIXMINDOWNED  15. DECEDENT'S EDUCATION  (Specify only highest grade completed)  16. DECEDENT'S USUAL OCCUPATION  (Give kind of work done during most of working  16. DO NOT use refired.)  17. FATHER'S NAME (First, Middle, Last)  JOHN JAMES GROSS  18. MOTNER'S NAME (First, Middle, Meiden Surmame)  SARAH ROUSBY	OUNTY OF DEATN  10d. INSIDE CITY LIMITS?  VX YES 2   CITIZEN OF WHAT COUNTRY?  ITED STATES  14. RACE — American India Black, White, etc.  Specify: BLACK
10e. STATE   10b. COUNTY   10c. CITY, TOWN OR LOCATION   BALTIMORE	10d. INSIDE CITY LIMITS?  VX YES 2   CITIZEN OF WHAT COUNTRY?  ITED STATES  14. RACE — American India Black, White, etc.  Specify: BLACK
106. STATE   106. COUNTY   106. CITY, TOWN OR LOCATION   BALTIMORE	CITIZEN OF WHAT COUNTRY? ITED STATES  14. RACE — American India Black, White, etc.  Specify: BLACK
10e. STREET AND NUMBER  3300 BENSON AVENUE APT. 329  11. MARITAL STATUS 1 Nover Micried 2 Merried 2 Merried 1 YES, GIVE WAR OR DATES  12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES  13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)  15. DECEDENT'S EDUCATION (Give kind of work done during most of working life. Do NOT use refered.)  16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refered.)  17. FATHER'S NAME (First, Middle, Last)  JOHN JAMES GROSS  109. ZIP CODE 21227=  UNI  18. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)  19. CARE PROVIDER  16b. KIND OF BUSINESS/N  CARE PROVIDER  17. FATHER'S NAME (First, Middle, Last)  JOHN JAMES GROSS	CITIZEN OF WHAT COUNTRY? ITED STATES  14. RACE — American India Black, White, etc.  Specify: BLACK
3300 BENSON AVENUE APT. 329  11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— 14 yes, specify Cuban, Maxican, Puerto Rican, etc.) 15. DECEDENT'S EDUCATION (Specify only highest grade completed)  16a. DECEDENT'S USUAL OCCUPATION (Specify only highest grade completed)  17. FATHER'S NAME (First, Middle, Last)  JOHN JAMES GROSS  18. MOTNER'S NAME (First, Middle, Meiden Surmame)  SARAH ROUSBY	ITED STATES  14. RACE — American India Black, White, etc.  Specify: BLACK
3 M/Midowed 4 Divorced  IF YES, GIVE WAR OR DATES  1 YES 2 M/NO Specify:  1 YES 2 M/NO Specify:  1 YES 2 M/NO Specify:  1 YES 2 M/NO Specify:  1 YES 2 M/NO Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON Specify:  1 ON	Specify: BLACK
(Specify only highest grade completed)  Elementary/Secondary (0-12)  11 th  CARE PROVIDER  10. MOTHER'S NAME (First, Middle, Lest)  JOHN JAMES GROSS  10. BECCEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  10. MOTHER'S NAME (First, Middle, Meiden Surmame)  SARAH ROUSBY	INDUSTRY
JOHN JAMES GROSS   SARAH ROUSBY	
JOHN JAMES GROSS SARAH ROUSBY	e else"s HOME
10a INFORMANT'S NAME (TransPrint)	7.0.1
DOVANE HARDY # 21230 - DOVANNE HARDY, 2418 ARBU	
206. NETHOD OF DISPOSITION 1 \( \tilde{\Omega} \) Auriel 2 \( \tilde{\omega} \) Cremetion 3 \( \tilde{\Omega} \) Removal from State 20b. PLACE AND OATE OF DISPOSITION (Name of complete or other place)	- City or Town, State
4 Donation 5 Other (Specify) GARRISON FOREST VA CEMETERY 5-3 OWIN	NGS MILLS,MD
Delivery of Johnson	NORTH AVENU
23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or reapiratory a shock, or heart failure. List only one ceuse on each lina.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Due TO (OR AS A CONSEQUENCE OF):	arreat, Approximinterval B. Onset and 2 Luc
Sequentially list conditions,  OUE TO (OR AS A CONSEQUENCE OF):	3 km
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. OUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):	
that initiated events resulting in death) LAST	
PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I.  ORF HTN, BROWNING  1 YES 2 DNO	AMAILABLE PRIOR COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF COMPLETION DF
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN	1 [] YES 2 [] A
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO 10 NO 10 NOTHER: 1 NO UNCERTAIN 10 NOTHER: 1 NO UNCERTAIN 10 NOTHER: 1 NOTHER: 1 NOTHER: 28. DATE OF INJURY AT WORK? 28. DATE OF INJURY AT WORK?	
T 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY AT WORK? 28c. INJURY AT WORK?	OCCURED
2 Accident Investigation M 1 YES 2 NO	
3 Suicide 8 Could not be determined 286. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 286. LOCATION (Street end Number City or Town, State)	per or Hural Houte Number,
29a. CERTIFIER (Check only one)  29b. CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and menner as st. one)  2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner as st. one)	
296. SIGNATURE AND TITLE OF CHATTERS 29d. DA	DATE SIGNED (Month, Day, Year)
20. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  B. TURAKHIA, MD 1009, Frederick Rd. Bellin	4/29/85
11 TUPAKULA COLO INTERPREDICTION OF POLICE	mare, ND 2/2
13. TO TOTALIT, MY 1009, Frederick Rd Gets	

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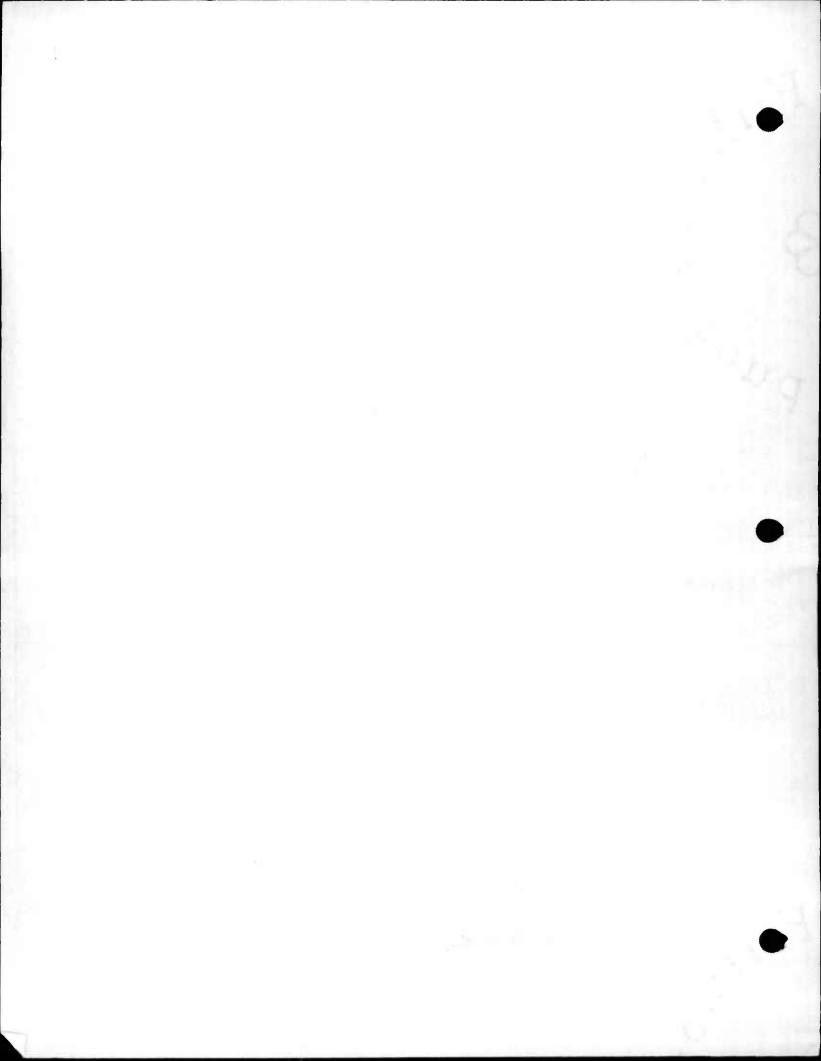
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND				MENTAL	HYGIENE
C	ERTIFICATE	OF DEAT	H		REG. NO.

	1 - STATE REGISTRAR	STATE OF MARY		TMENT OF H CATE OF		MENTAL HYGIENI REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, L.	est)				2. DATE OF DEATH		3. TIME OF DEATH
	WARREN	DOUGLAS	WILME	R, SR.		APRIL 22	, 1995	1:15P M
	4. SOCIAL SECURITY NUMBER 220-04-0439	1 <del>/</del> 2/M 2 □ F	(In yrs. lest birthday) 39 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 2-8-56	Cour	THPLACE (State or Foreign ntry)
~	9e. FACILITY NAME (If not institution, g				R LOCATION OF DE		9c. COUNTY OF	
DIRECTOR	5918 HAMLIN			BAL'	TIMORE	CITY	N/2	A
EC	10a. STATE 10b. CO		10c. CITY	TOWN OR LOCAT	ION			10d, INSIDE CITY
	MD	N/A	BA	LTIMORE	E CITY			1 X YES 2 NO
FUNERAL	100, STREET AND NUMBER 935 N. WASHI	INGTON ST.		101.	ZIP CODE 2120	5	10g. CITIZEN OF	WHAT COUNTRY?
BY	11. MARITAL STATUS  11. Marital Status  12. Merried 2 Merried  3 Widowed 4 Divorced	IN U.S. ARMED 2 (XNO DATES	ARMED  13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No If yes, specify Cuben, Mexicen, Puerto Ricen, stc.)				14. RACE — American Indian, Black, White, etc.	
COMPLETED	15. DECEDENT'S (Specify only highest g		16a. DECEDENT'S I	JSUAL OCCUPATIO	N of al working	186. KIND OF BUS		
LET	Elementary/Secondary (0-12)	College (1-4 or 5+)		ork done during mos retired.}				
MP	12	N/A	CONSTR	UCTION	WORKER			TRUCTION CO
BE CO	17. FATHER'S NAME (First, Middle, Leat) CHARLES	DOUGLAS		LMER	CURTIE	ME (First, Middle, Meiden	SMITH	
5	19e. INFORMANT'S NAME (Type/Print)					Poute Number, City or Town		V200
	CURTIE BERRYN 200. METHOD OF DISPOSITION							MD 21205
	1 Buriel 2 Cremetion 3 F 4 Donation 5 Other (Specify)		b. PLACE AND DATE O			4/27 BA	CATION — City or	Town, State
	21. SIGNATION OF FUNERAL SERVICE	LICONSEE	OSUELL	22. NAME AN	D ADDRESS OF FAC	4/2/ BAI	LTIMORI	E, MD.
	Louelly	Viona	to	1129n	n N. CA	BETTS I	FUNERAI F. BALT	L HOOME TO,MD21213
	23. PART Enter the diseases, shock, or heart fells IMMEDIATE CAUSE (Fine disease or condition resulting in death)	ire. List only one cause on a	nach lina.	ot emai tha mot	aa or dying, suci	n as cardiac or raapii	ratory arrast,	Approximate Interval Batween Onset and Daath
RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS .	A CONSEQUENCE OF	remia				1415
CERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b. MAC DUE TO (OR AS C. DUE TO (OR AS DUE TO (OR AS	bacte A CONSEQUENCE OF	remia nitis				
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n. Page 6 may be retained by	eral director, page 5 should be		ONTAIN: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
ted within surs after death	completely filled in by the fund	ial, cremation, or removal.	event, the medical exan
the death certificate be execu-	the attending physician and	1 Mental Hygiene prior to buri	Injury, or other traumatic
iCIAN: The law requires that	ertificate has been signed by	the State Dept. of Health and	or item 23 shows any
SPITAL DR ATTENDING PHYSI	NERAL DIRECTOR: After this c	ed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	NT. If item 28 is marked,
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH WARNER ELIZA BETH 28 5,55p " 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTNPLACE (State or Foreign 32 De C 9 109 1 M 2 KF 8 89 13 9b. CIFY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR RESIDENCE OF DECEDEN 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Bunie 1 TES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8 21060 U.S. A norric 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No-11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. APMED 14. RACE — American Indian Black, White, etc. If yes, specify Cube FORCES? 1 YES 2 2 Merried Specify: B 3 Widowed 4 N Divorced ack COMPLETED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe College (1-4 or 5+) Norker -25TIC omestic 19 17. FATHER'S NAME (First, Middle, La 18. MQTHER'S NAME (First, Middle, Maiden Surne BE 190. INFORMANT'S NAME (Typo/Print) 196. MAILING ADDRESS (Street and Number or Pural Poute Number, City or Jawn, State, Zip Code) 2 21060 Ne roe MD 20a METHOD OF DISPOSITION 1 D. Burlel 2 Cremation 206. PLACE OF DISPOSITION (No. 20c. LOCATION -- City or Town, State md 3 🗆 F men. Arbutus, 4 Donation 5 Other (Specify) 22. NAME AND ADDRESS OF FACILITY 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ma 300 a 23. PART I/Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate nock, or heart fellure. List only one ceuse on each line interval Between IMMEDIATE CAUSE (Final **Onaet and Death** disease or condition resulting in death) PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR/AS A CONSEQUENCE OF . Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death pyt not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS et orch Lema COMPLETION OF CAUSE 1 - YES 2 NO OF DEATH? 1 | YES 2 | NO

25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH (Check only one)								
EXAMINER?	HOSPITAL: 1   Inpetient 2	ER/Outpatient 3 DOA	OTHE	8 Other (Specify)						
27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF (Month, Da		ME OF JURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCCURED					
3 Suicide 8 Could not be		INJURY — At home, farm, etc. (Specify)	street, fa	281. LOCATION (Street end Number or Rural Route Number, City or Town, State)						

1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date end piece, and due to the cause(e) end menner ee stated.

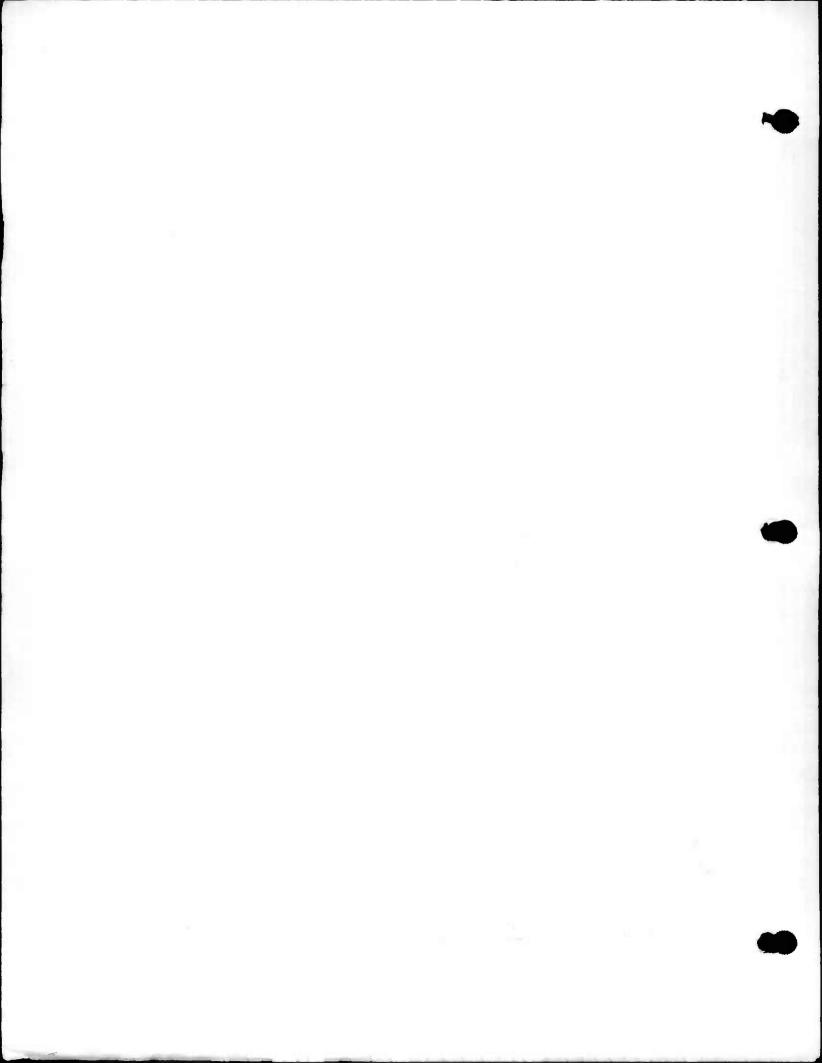
2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and menner se stated.

SIGNATURE AND TITLE OF CERTIFIER	Ottendung	Doctor	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)

30. NAME

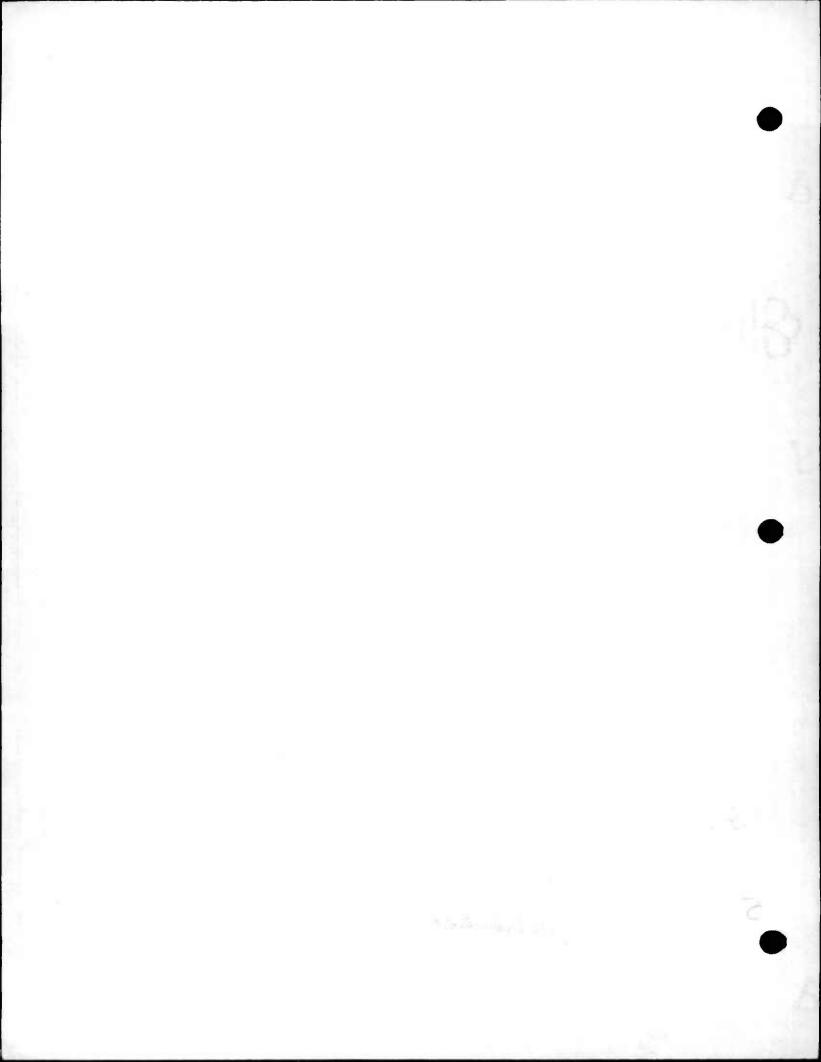
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	FOR 1 - STATE REGISTRAR	STATE OF MA							MENTA			J	
	1. DECEDENT'S NAME (First, Middle, Last)	R.	Aire		ICATE	UF	DEA	I II	2. DAT	REG. NO.	8	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 213 01 6654		AGE (In yrs. les		IF UNDER	1 YEAR DAYS	IF UNDE	R 24 HRS.	7. DATE (Mon	OF BIRTH		a. BIRTH County	IPLACE (State or Foreign
OR	9a. FACILITY NAME (If not institution, give str Bay View Medical						MINOT	ION OF DI	EATH		9c. COU	A	EATH
DIRECTOR	10a. STATE 10b. COUNTY N/A				10c. CITY, TOWN OR LOCATION Baltimore								10d. INSIDE CITY LIMITS? 1 2 YES 2 NO
FUNERAL	3611 Foster Avenu	ie				101	212	_		-	10g. CITI		WHAT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	VER IN U.S. AR YES 2 A OR DATES	RMED NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No- If yes, specify Cuban, Maxican, Puarto Rican, etc.)  1 YES 2 NO Specify:  White										
ETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	CATION completed) Coffege (1-4 or 5 +)	16a. DE (G life.	CEDENT'S ive kind of Do NOT u	USUAL Of work done of se retired.)	CCUPATIO	ON st of worki	ng	16	b. KIND OF BUS	INESS/IND		
COMPLET	8 17. FATHER'S NAME (First, Micidle, Last)			House	ewor}	ς	18. MOT	HER'S NA	ME (First.	At Ho	1111		
BE	William Ruth  198. INFORMANT'S NAME (Type/Print)		100	SAAH ING	ADDRESS					Middle, Maiden lonski			
임	Patricia Warnick  196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6812 Crossway Dundalk, Md. 21222												
	20a. METHOD OF DISPOSITION  1 for Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)  Sacred Heart of Jesus Cem. 5-1-95 Dundalk, Md.												
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY Charles S. Zeiler & Son Inc. 901 S. Conkling St. Balto., Md.												
	23. PART I. Enter the disease, or compileations that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory errest, ahock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST  B. HOER Kalenta  DUE TO (OR AS A CONSEQUENCE OF):  C. LOG Stage Cental description  DUE TO (OR AS A CONSEQUENCE OF):  d.												
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PHYSICIAN:	DID TOBACCO SE CONTR  25. WAS CASE REFERRED TO MEDICAL EXAMINER?				S		UNC	ERTAIN	N B				
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ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, 1		INJ	M	t 🗌 Y	RK7 'E\$ 2 [	] NO					
9	3 Suicide 6 Could not be 4 Homicide determined	26a. PLACE OF IN building, etc.	(Specify)	ne, farm, i	street, facti	ory, office			261. LOC City	CATION (Street as or Town, State)	nd Number	or Rural R	loute Number,
COMP	29a. CERTIFIER (Check only one)  1 CERTIFYING PHYSIC 2 MEDICAL EXAMINER	CIAN: To the best of my											) and manner as steted.
TO BE (	296. SIGNATURE AND TITLE OF CERTIFIER  30. NAME AND ADDRESS OF PERSON MIO	COMPLETED CAUSE (	HOUS OF DEATH (ITEM	SES	tas Print)	2	29c. LICI	BOI	(BER		29d. DATE	SIGNED	(Month, Day, Year) 8195
	RITA HARDY  31. DATE FILED (Month, Day, Year)  MAY 0 2 1995 Fall		AY AI			DICA	L C	Œ NT	1	494	YE	A 51	ERN AU.



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	010 00 1101		E (th yrs. lest birt	YRS. IF U	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) OCTODEY 1	8.		ACE (State or Foreign	
TOR	90. FACILITY NAME (# not institution, give street Northwest Hospita			9b.		or Location of DE		Ba1		re County	
DIRECTOR	10a. STATE 10b. COUNTY	more County			onsvil					d. INSIDE CITY LIMITS?  YES 2 NO	
FUNERAL	100. STREET AND NUMBER 5920 Moorehead Roa	ıd			101	7. ZIP CODE 21228		10g. CITIZEI US	N OF WHA	T COUNTRY?	
B	11. MARITAL STATUS  1 Never Married 2 Recried  3 Vidowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	8 2 NO		If yes, spi	CENDENT OF HISPAN Decity Cuben, Mexica 3 2 ANO Specify	NIC ORIGIN? (Specify Years, Puerto Rican, etc.)	e or No 14	Specify:	American Indian, thite, etc.	
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade or Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5+)	(Give ki	DENT'S USUA dind of work of NOT use retir		ON ost of working	16b. KIND OF BU	e Impro	STRY		
BE COM		liam Ashby					ME (First, Middle, Maiden Thelma Mo	Sumeme) OOTE			
2	190. INFORMANT'S NAME (Type/Print) Ms. Faith Ashby		19b. MA 592	AILING ADDI	ness (Street e orehea	and Number or Rural I	Route Number, City or Tow Catonsvil	vn, State, Zip Co 1e, MD	2122	28	
	20e. METHOD OF DISPOSITION  1 Burlel 2.0 Cremation 3 Remove  4 Donation 5 Other (Specify)	val from State	06. PLACE AND I	e vest	ingtan	Crematory	4 28 95 Lau	urel, I		State	
	21. SIGNATURE OF FUNERAL SERVICE LICEN	Sel		0535	Elli	cott Cit	al Home, P cy, Marylan	nd 2104			
	23. PART I. Enter the diseases, pr-co- ehock, or heert fellure. Li IMMEDIATE CAUSE (Finel disease or condition	mplications that cause let only one cause on	eech line.	/	^		,			Approximata Interval Between Onset and Death	
z	disease or condition resulting in death)  a. A thurs durate CAPROVASCO (AV DISEASE ZO JEARS  DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions.  b. The per tension of the conditions.										
CATIO	Sequentially list conditiona, if any, leeding to immediate cause. Enter UNDERLYING	DUE TO (OR AS	DUE TO (OR AS A CONSEQUENCE OF):  SMBKIKG							201400	
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUEN	ICE OF):	7					ec yes	
MEDICAL C	PART II. Other algnificent conditions	contributing to deeth	but not resul	ting in the	underlying	g cause given in	Part I. 24a, WAS AN PERFOR	RMED?	CO	RE AUTOPSY FINDINGS ALLABLE PRIOR TO MPLETION OF CAUSE DEATH?	
AN: ME	DID TOBACCO USE CONTRII	BUTE TO CAUSE (	OF DEATH	YES X	NO 🗆	UNCERTAIN	<u> </u>			YES 2 NO	
200	EXAMINER?	HOSPITAL:		OTI	HER:	ie 5 🗆 Reeldence	A Cother (Specify)				
BY PHYSICIAN:	27. MANNER OF DEATH  1 Netural 5 Pending  1 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	7 281	b. TIME OF	28c. INJU		28d. DESCRIBE HOW I	NJURY OCCUR	IED		
	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJUR building, etc. (Spe	tY — At home, f	erm, atreet,	factory, office	•	281, LOCATION (Street of City or Town, State)	and Number or i	Rural Route	Number,	
COMPLETED		IAN: To the best of my know							euse(s) en	d manner se stated.	
띪	29b. SIGNATURE AND TITLE OF CERTIFIER	Mutu	1	wi	5	D 414		29d. DATE SI	IGNED (Mo	onth, Day, Year) 26, 1985	
임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF D	EATH (ITEM 27	(Time Print)				11/	-16 -	4777	

PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

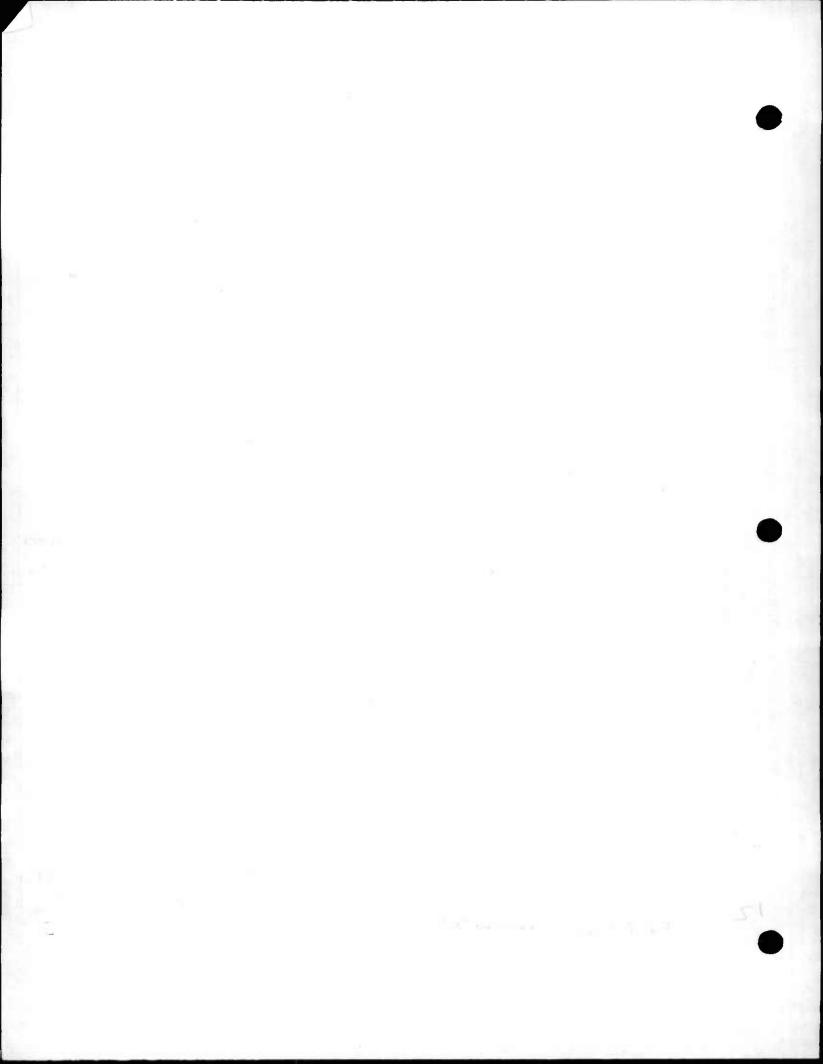
Kes thwest

A MORTHERS

T- TLANCISCO

31. DATE FILED (MONTH, Day, Mars)

MAY 0 2 1995



FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH

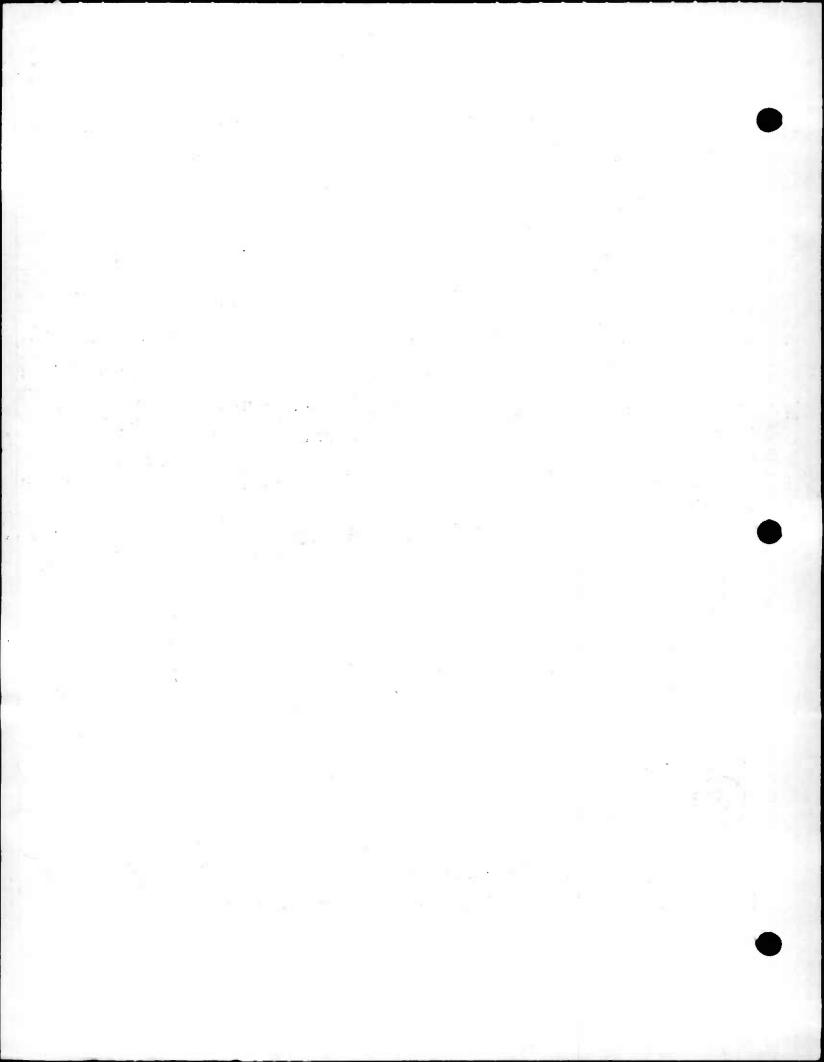
REG. NO.

1		REGISTRAR		CE	RTIF	CATE C	F DEATH	REG. NO	).	
		1. DECEDENT'S NAME (First, Middle, La	st)					2. DATE OF DEATH		3. TIME OF DEATH
	1	AUGUST	HERMAN A	FFELD	${f T}$			APRIL 2	5 180	12:15 PM
	1	4. SOCIAL SECURITY NUMBER	5. SEX 6	. AGE (In yrs. les	t birthday)	IF UNDER 1 YEA	R IF UNDER 24 HRS.	7. DATE OF BIRTH	101	BIRTHPLACE (State or Foreign
		216-24-6370	1 525M 2 □ F	65	YRS.	MONTHS DAY		(Month, Day, Year)		Country)
pind		9a. FACILITY NAME (If not institution, gi		0.5		DL OUTY TOU		May 9,192		aryland
3 should	æ	The Second Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of					N OR LOCATION OF D		9c. COUNTY	OF OEATH
2,	DIRECTOR	UNION MEMORI		'AL		BALT	IMORE C	LTY	N/A	
- S	낊	10a. STATE 10b. COU			100 0170	/ TOWN OR 10				
Pages	<u>E</u>	1.000110175			10c. CITY, TOWN OR LOCATION					19d. INSIDE CITY LIMITS?
permit.			timore Coun	ıty		Catons	<i>I</i> ılle			1 TYES TO THE
	₹	10e. STREET AND NUMBER					101. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
n. ansit	i i	2414 Rockwell A	venue				2122	28	USA	
020 physician. bunal-transit	FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT (FORCES? 1	YER IN U.S. AR	MED	13. WAS I	DECENDENT OF HISPA	NIC ORIGIN? (Specify Ye	s or No 14.	RACE — American Indian,
E 3		1 Never Married 2 Married	IF YES, GIVE WAR	FINES 2 IN	10		specify Cuberi, Maxico			Black, White, etc. Specify:
215-0 attending se as the	ВУ	3 Widowed 4 Divorced		9-48/	5-52		ALPRO Open	,		white
21215-0020 al or attending physic for use as the bunial	COMPLETED	15. DECEDENT'S E (Specify only highest gr	DUCATION	16a. DE:	CEDENT'S	USUAL OCCUP	ATION	16b. KIND OF BU	SINESS/INDUST	
21 al or for u	Ш	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT use	rork done during e retired.)	most of working			
	4	9		7	Millh	bece		m		
AND the hospit detached once.	8	17. FATHER'S NAME (First, Middle, Last)				land	40 44071177177	ME (First, Middle, Meiden	tile M	111
YLA by the be det			H. Affeldt	Cr.					,	
MARY stained to should	8	19a. INFORMANT'S NAME (Type/Print)	II. ALICIAL					ra May Sch	- M	
MARYLAND retained by the hospit 5 should be detached notified at once.	2							Route Number, City or Tow		
	7 [	Mr. Robert Affe	lat		505 S	Weet E	Brush Cour	t, Severna	Park,	MD 21146
THE THE ST. PAGE 18		20a. METHOD OF DISPOSITION 1 □ Disposition 3 □ R	emoval from State	20b. PLACE A	NDDATEO	FDISPOSITION	(Neme of	DATE 20c. LO	CATION - City	or Town, State
O 6 5 51		4 Donation 5 Other (Specify)		Meador	wrida	w Memo	rial Park	4/28/95	Eller	idye, MD
BALTIM after death. Page by the funeral dire- noval.		21. SIGNATURE OF FUNERAL SERVICE	LICENSEE			22. NAME	AND ADDRESS OF FA	CILITY		ruge/ no
tuner funer	:	11/1/1/	11	1.00	2505			ral Home,		
0 0 0 0		francian	feller C		0535	<u>F</u>	Ellicott C	ity, Maryl	and 210	043
rem rem		23. PART I. Enter the diseases (	or complications that c be. List only one cause	aused the de	ath. Do no	ot enter the	mode of dying, aud	h aa cerdiac or reap	Iratory arreat,	Approximata
hou hou		IMMEDIATE CAUSE (Finel	o. List only one cause	On each line.						Interval Between Onset and Death
ily fill	ľ	disease or condition	I.IK	IGAL	4	DTICK	MIA			15 Jaus
with plete crem	1	resulting in death)	a. 70/V	R AS A CONSEC	UENCE OF			0		aug
OX 68760  E be executed within the hours affer sician and completely filled in by the ridor to burial, cremation, or remove traumatic event, the medical	- 1		PAI	VCDEA.	TIC	ABO	CECTE	RECURR	PEAT	2. 2 MOVZ
and and o bu	CERTIFICATION	Sequentially list conditions,	b. DUE TO (OI	R AS A CONSEC	LIENCE OF					0211011
a lician	AT	If any, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or injury c. INFECTED PANCKENTIC PSEUDO CYCLS								1-7 Vrae
Dhys phys	윤	CAUSE (Disease or injury	c. ////	RAS A CONSEC	HENCE DE	TACKE	11/10/			TEIL
Syde of the O	Ē	that initiated events resulting in death) LAST	40	1117	120	ann	and (	Romerco	VIAMO	OME ~ ZMONTE
tal Hy	典		d	111	KES	PIKM	TURY A	BINESS	DYIVUK	OFIE CHONIE
the deal y the attr of Mental	- 11	PART II. Other eignificant conditi	ons contributing to de	ath but not re	eulting in	n the underly	ing cause given in	Pert I. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS
E =	SA S	HSDIVATTO.		MONIA.			g occoo given iii	PERFOR		AVAILABLE PRIOR TO
signed Health &		1/04/201	TOADIE	TUNIO	INCI	2001		1 X YES 2	□ NO	OF DEATH?
REC requir	Z	MRINARY	IKACT			1/0W		_ /		1 TYES 2 NO
	ä	DID TOBACCO USE CON	TRIBUTE TO CAUS	SE OF DEAT	TH YES	S NO	□ UNCERTAIL	1,22		
ITAL V: The law cate has State Depritem 23	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACI	OF DEATH	H (Check only o	ne)	7		
AN: 1	Sic	1 YES 2 NO	HOSPITAL:	R/Outpetient 3		OTHER:	ome 5 🗆 Rasidenca	B C Other (Specific)		
ION OF VITA	È∥	27. MANNER OF DEATH	28a. DATE OF IN.		28b. TIME		INJURY AT	28d. DESCRIBE HOW I	N.IIIRY OCCUPE	0
O 축 를 풀 호		1 Natural 5 Pending	(Month, Day,	Year)	INJU	JRY	WORK?	Eva. Degoniae non p		
SION DH Affer death ma	B	2 Accident Investigatio	284 PLACE OF II	MILIEN At her						
S H H H		3 Suicide 8 Could not t	building, etc	(Specify)	ne, term, st	reet, rectory, or	rrica	28t. LOCATION (Street & City or Town, State)	and Number or Ru	iral Route Number,
( E E	E									
5 0 4 2		(Check only 1 CERTIFYING PH	SICIAN: To the beat of my	knowledge, des	th occurred	d at the time, d	eta and place, and dua	to the cause(s) and mar	ner as stated.	
1	COMPL	one) 2 MEDICAL EXAM	MER: On the beels of exeg	maion and/or in	westigation	, in my opinion	, death occured at the	time, data and place, an	d due to the cau	use(s) and manner as stated,
SO THE WAY		296. SIGNATURE AND TITLE OF CERTIF	4/	/						
TO THE HOS TO THE FUN be filed with	H H	+anaile	INO. MA	Male	M		29c. LICENSE NUI	CAUL-CAS	29d. DATE SIG	NED (Month, Day, Year)
2 6 3 ₹	2	- propine	10	1000			A1 49	170 100	PIIIK	10 15/110
-		30. NAME AND ADDRESS OF PERSON I	NHO COMPLETED CAUSE	DEATH (ITEM	27) (Type, 1	Print)		111		
4		NACHNE	UNE KO	yet	MI	7	Un	4		
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S	SIGNATURE /						
		MAY 0 2 1995 S	who divoler	lardall						
		THE RESERVE OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE								

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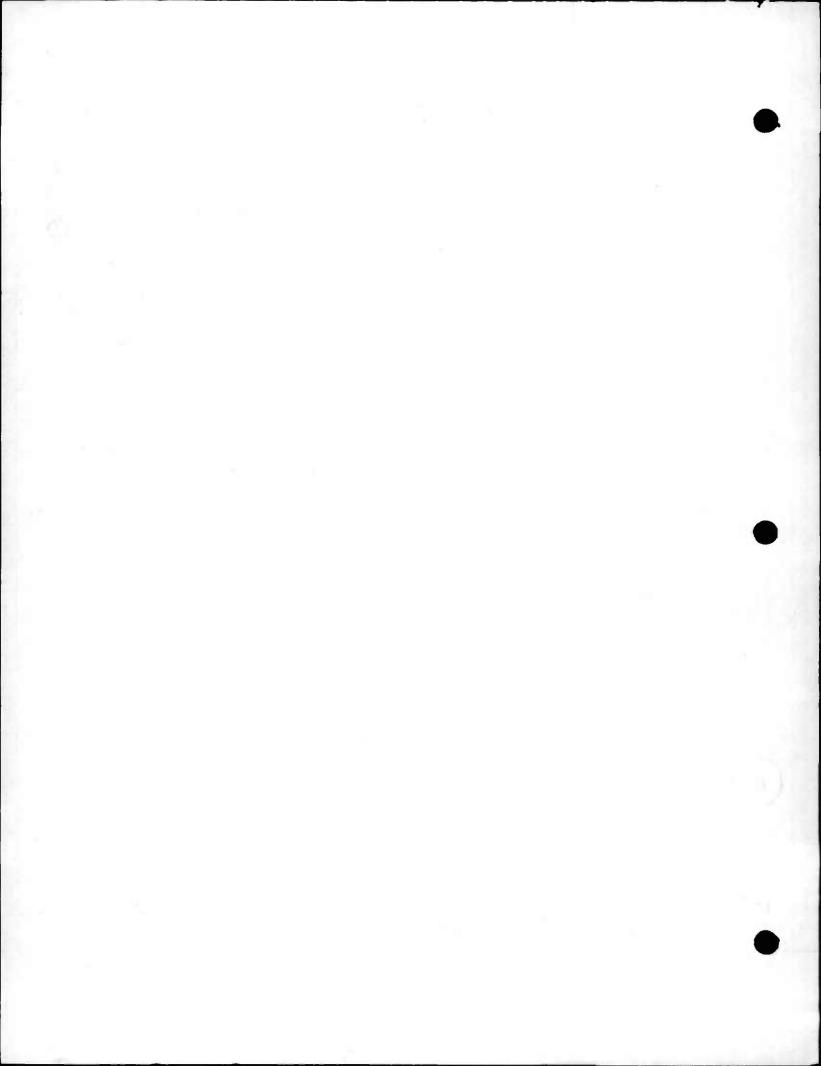
PFIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	HEAR Unrecome that the State Deen signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	mentions are not considered by the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of the constraint of	TOOLS OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE P
TO THE HISSPITA	TO THE PUNERAL	IMPORTANT M	

							9	5 13172			
	1 - FOR STATE 0			TMENT OF		MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)  CLARENCE (	+m Du	IR			2. DATE OF DEATH MONTH		3. TIME OF OEATN			
	4. SOCIAL SECURITY NUMBER  2/6-0/-6528  1 □ 24 2 □	6. AGE (In yrs. Is 82	rst birthday) YRS.	MONTHS DAYS HOURS MIN. (Month, Day, Year)			BIRTHPLACE (State or Foreign Country) MARYLAND				
E .	9a. FACILITY NAME (If not institution, give street and number,			96. CITY, TOWN OR LOCATION OF DEATN 96. COUNTY OF BALTIMORE N/A							
DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY		10c. CITY, TOWN OR LOCATION			5.7	10d, INSIDE CITY				
	MARYLAND N/A		BAI	TIMORE	0.00			LIMITS?			
FUNERAL	100. STREET AND NUMBER 5409 GIST AVE.			10	or. ZIP CODE	1215	10g. CITIZE	N OF WHAT COUNTRY? USA			
ON I	11, MARITAL STATUS 12, WAS DECE	DENT EVER IN U.S. A		13. WAS DE		IIC ORIGIN? (Specify Yes	or No— 14	I. RACE — American Indian,			
BY	3   Widowed 4   Divorced	Wildowed 4 Divorced 97777.				If yes, specify Cuben, Mexican, Puerto Rican, etc.)  1 YES 2 NO Specify:					
TE	15. DECEDENT'S EDUCATION (Specify only highest grade completed)		ECEDENT'S Give kind of w e. Do NOT use	USUAL OCCUPAT rork done during m e retired.)	ION lost of working	16b, KIND OF BUS	SINESS/INDUS	TRY			
COMPLETED	Elamentery/Secondary (0-12) College (1-4 o	r 5+)		LY OFFI	CER	U.	.S. GO	VERNMENT			
6 m	17. FATHER'S NAME (First, Middle, Last) ABE	Al	MDUR		18. MOTNER'S NA KATE	ME (First, Middle, Maiden	Surname)	VISOKOLSKY			
2	190. INFORMANT'S NAME (Type/Print)  MRS. LILLIAN AMDUR	16	66. MAILING 540	ADDRESS (Street 09 GIST	AVE . BAI	TIMORE, MI	212f	5 5			
	20b. PLACE AND DATE OF DISPOSITION    Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Description   Descri										
CERTIFICATION	23. PART I. Effect the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reepiratory arrest, in the condition resulting in deeth)  Due to (or as a consequence or):  Sequentially list conditions, if am, leading to immediate cause. Enter UNDERLYING							t, Approximata interval Between Onset and Death			
	CAUSE (Disease or injury that initieted events resulting in death) LAST	TO (OR AS A CONSE	QUENCE OF	):							
N: MEDICAL	Prostatic Hy D DID TOBACCO USE CONTRIBUTE TO	PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I.  (PVED TO VASCULAY ACC   CR   THE PRIOR TO COMPLETION OF DEATH OF LAURE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO 1 Inception			H (Check only one) OTHER:							
H	27. MANNER OF DEATH 28s. DATE	OF INJURY	28b. TIME	OF 28c. IN.	JURY AT	8 U Other (Specify)  26d. DESCRIBE NOW II	NJURY OCCUR	RED			
ě.	2 Accident Investigation			M 1 🗆	YES 2 NO						
4	3 Suicide 8 Could not be determined 28e. PLAC build	E OF INJURY — At he ng, atc. (Specify)	ome, farm, st	treet, factory, offic	ç•	28t, LOCATION (Street a City or Town, State)	and Number or	Rural Route Number,			
COMPLE	29a. CERTIFIER (Check only one)  2 MEDICAL EXAMINER: On the bear										
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	am			AS242	12321AM	≥ A F	IGNED (Month, Day, Year)			
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED OF	VAI HOS	PITAL	LOF 9	BALTIM	ORE					
	MAY 0 2 1995 July Dave	TRAR'S SIGNATURE									



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR	CERTIF	CALE	OF DEATH	REG. NO	).				
	1. DECEDENT'S NAME (First, Middle, Least)	1 mas	5	<b>/</b>	4 3	NV C	YEAR 3. TIME OF DEATH			
	212-01-63,7 15/M2DF	GE (In yrs. lest birthday)  FUNDER 1 YEAR  FUNDER 24 HR  MONTHS DAYS HOURS MH			7. DATE OF BIRTH (Month, Day, Year)		s, BIRTHPLACE (State or Foreign Country) Maryland			
TOR	St. Elizabeth Nursing Home  RESIDENCE OF DECEDENT		Baltin	WN OR LOCATION OF DEA	ATH	9c. COUN	TY OF DEATH N/A			
DIRECTOR	100. STATE 10b. COUNTY Maryland Baltimore		, TOWN OR LO	OCATION			10d. INSIDE CITY LIMITS? Y 1 YES 2 NO			
	10e. STREET AND NUMBER			101. ZIP CODE		EN OF WHAT COUNTRY?				
FUNERAL	324 Wessling Circle 11. MARITAL STATUS 12. WAS DECEDENT EVER II			21228			.S.A.			
B≺	11. MARITAL STATUS  1 Never Married 2 Merried  3 Wildowed 4 Divorced  12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR D	2 (X)NO	If you	DECENDENT OF HISPANI s, specify Cuben, Mexican YES 2 1 NO Specify:	, Puerto Rican, etc.)	s or No—	14. RACE — American Indian, Black, White, etc. Specify: White			
冒	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a, DECEDENT'S (Give kind of w life. Do NOT us	rork done during	PATION a most of working	16b. KIND OF BU	ISINESS/INDU	JSTRY			
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)	Fireman	e reureu.;		Baltimore	e City I	Fire Department			
8	17. FATHER'S NAME (First, Middle, Last)	<del></del>		250000	NE (First, Middle, Maider	Surname)				
BE	Edward Lee Amos  190. INFORMANT'S NAME (Typo/Print)				t Stafford					
2	Edward F. Amos Jr			oet end Number or Rural R Drive Ellico						
		PLACE AND DATE O	F DISPOSITION				City or Town, State			
		estlawn Ce	neterv	May 3.	1995 Mari	iottsv	ille. Maryland			
	· Luneway it	e		E AND ADDRESS OF FAC M. & RUSSEL Edmondson Ave						
	23. PART I. Enter the diseases, or complications that caused shock, or heart tallura. List only one cause on a	d the death. Do n	Ot antar tha	moda ot dying, such	as cardiac or resp	iretory arre	est, Approximate			
			31.4	ler conce			Onset and Daath			
	resulting in death) Due To (OR AS A	CONSEQUENCE OF	) 1/00 D:	4 5010						
Z	Sequentially list conditions,									
EDICAL CERTIFICATION	It sny, leading to immediate cause. Enter UNDERLYING	A CONSEQUENCE OF	ን:							
띮	that initiated events	CONSEQUENCE OF	ŋ:							
ERI	resulting in death) LAST									
AL (	PART II. Other significant conditions contributing to death b	out not resulting i	n tha under	ying cause given in f	Part I. 24a. WAS AI	N AUTOPSY RMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
8	Demention: wima	1 to day	) ( yen	0	1 YES	2 <b>&gt;</b> NO	COMPLETION OF CAUSE OF DEATH?			
Σ	D D	CAUSE OF	DEATH	VEC III NO			1 TYES 2 NO			
SIAN	DID TOBACCO USE CONTRIBUTE TO 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	CAUSE OF	2	YES NO						
PHYSICIAN	1 YES 2 DENO 1 Inpatient 2 ER/Outs			Home 5 - Reeldence	B Other (Specify)					
ву Рн	27. MANNER OF DEATH  1 Naturel 5 Pending 2 Accident Investigation  28e. DATE OF INJURY (Month, Day, Year)	28b. TIMI	M 1	INJURY AT WORK?	28d. DESCRIBE HOW					
	3 Sulcide 6 Could not be determined 28e. PLACE OF INJURY building, etc. (Special Could not be determined)	/ — At home, ferm, a	treet, lectory,	office	281, LOCATION (Street City or Town, State	and Number (	or Rural Route Number,			
COMPLETED	29e. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my know one)  2 MEDICAL EXAMINER: On the basic of examination									
TO BE	296. SIGNATURE AND TITLE OF GERTIFIER . Train			29c. LICENSE NUM  D3 4 8		29d. DATE	SIGNED (Month, Day, Year)			
		5 Franks	Print)	I buk.	100 Cuts	ml	Las rorry			
	MAY 0 2 1995 Julia Drubler North	LATURE LAND								



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1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

		1. DECEDENT'S NAME (First, Middle, Last)  2. DATE OF DEATH MONTH DAY VEAR ADT. 29.1995								3. TIME OF DEATH		
										2:50 p.		
		4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE	(In yrs. les	-	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH		BIRTHP	LACE (State or Foreign
ш.		216-28-8993	1 🕅 M 2 □ F 6	6	YRS.	SYAG SHTHC	HOURS MIN.		, Day, Year) 10 <b>–</b> 28		Country)	and the same of
plnots		9a. FACILITY NAME (If not institution, give	street and number)	0	9	b. CITY, TOWN	OR LOCATION OF D		10-20	9c. COUNT	Y OF DE	Md
2, 3 s	стоя	241 Williams	Rd.			Fern	dale					undel
- S	ا <u>ن</u> ا	10e. STATE 10b. COUNT	ry		10c CITY 1	TOWN OR LOCA						
Pages	DIRE	363									- 1	10d. INSIDE CITY LIMITS?
permit.		MQ Ann		77		rndal	Of, ZIP CODE			44- 017/70		1 YES 2 THO
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e gett	PL A	N/A	N/A	P	ngt (	ffice	9		II. S	G. Gov	ern	ment.
The hospit detached detached	ő	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First, A			011	IMC11 U
3 8 G	1 111	Michael	D. Byrne					Nell	ie Sv	rift.		
mak retained by 5 should b	B	19a. INFORMANT'S NAME (Type/Print)		198	. MAILING AC	DRESS (Street	and Number or Rural				ode)	
	2	Elizabeth M. 1	Byrne				ms Rd					767
may be or, page		20e. METHOD OF DISPOSITION	20	b. PLACE A	NO DATE OF	DISPOSITION (N	ame of	DATI		CATION — CIT		
ML I IMOR Jeath. Page 6 ma funeral director, p		Burial 2 ☐ Cremetion 3 ☐ Ren     Donation 5 ☐ Other (Specify)		metery, crei	netory or other	place)	ta Com	15				zille Md
		21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	C WI	SVII	22. NAME A	NO ADDRESS OF FA	VCILITY	199	Crov	vnsy	ville, Ma
death. Page tuneral di		. O. fram	~ John	L	-	5151	Baltim	ore	Nati	onal	Pil	ce
			Schwab			Ralt	imore.	Md.	2122	9		
		23. PART i. Enter the diseases, or shock, or heart failure.	complications that ceuse List only one cause on	d the de	eth. Do not	enter the me	ode of dying, suc	h aa card	iec or respi	ratory arres	t,	Approximate
S S S E		IMMEDIATE CAUSE (Final	•				/					Onset and Deat
and and		disease or condition resulting in death)	Ma/15	a Ma	nt.	Me	1ano	TWY	94			12415
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		CAUSE (Disease or injury	c									
nding phy Hygiene	별	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEO	UENCE OF):							
	CERTIFI	resolding in death) LAST	d									
E Me		PART II. Other aignificant condition	na contributing to death	but not n	saulting in t	he underlyin	G ceuse given in	Part i	24a. WAS AN	AUTOBOV	I	WEST ALITOROV FINDINGS
2 55 -	DICAL						g couse given in	r art i.	PERFOR		1	VERE AUTOPSY FINDINGS
signed Health a	<u>E</u>							— i	1 TYES 2	NO		COMPLETION OF CAUSE OF DEATH?
9 0 0	Σ	DID TODACCO LICE CONT	DIDLITE TO CALLES			<u> </u>			•		1	YES 2 NO
SiCIAN: The law certificate has be to the State Dept.	PHYSICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	KIBUTE TO CAUSE C					ИП				
V: The cate has State D	<u>고</u>	EXAMINER?	HOSPITAL:		0	Check only one)	1					
ATTENDING PHYSICIAN: ECTOR: After this certificals after death with the St.  28 is marked, or it	ΥS	1 VES 2 NO 27. MANNER OF DEATH	1 inpetient 2 ER/Out	patient 3		☐ Nursing Hon	-					
The with	ᇳ	1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)		28b. TIME O	Y WO	JURY AT ORK?	28d. DE\$	CRIBE HOW IN	IJURY OCCUP	RED	
DING PHYS After this death with	à	2 Accident Investigation					YES 2 NO					
TTENDI TTOR: A after d	8	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJUR' building, etc. (Spe	Y — At hor ecify)	ne, ferm, atre	et, factory, offic	ie .	281. LOCA City o	TION (Street e. r Town, Stete)	nd Number or	Rural Ro	ute Number,
OR ATTENDING DIRECTOR: After hours after death tem 28 is ma	E	in .										
	립	(Check only	ICIAN: To the best of my know	wledge, des	th occurred a	it the time, date	end place, end due	to the cau	se(e) end man	ner ee stated.		
	COMPLET	one) 2 MEDICAL EXAMINI	ER: On the basis of examination	on end/or li	vestigation, i	n my opinion, o	leath occured at the	time, date	end place, end	due to the c	anse(e)	and manner as stated.
E FUI	E C	296. SIGNATURE AND TITLE OF CERTIFIE	A / W	7			29c. LICENSE NUI	MBER		29d. DATE S	IGNED (	Month, Day, Year)
TO THE HOSPI TO THE FUNES be filed within	00	Senil Al	on En	200	-		1070	450	2	15	1	195
	유	30. NAME AND ADDRESS OF PERSON WI	O COMPLETEO CAUSE OF DE	EATH (ITEN	1 27) (Type, Pri	nt)		700	- 1		1	217.2
+1		MUID A VIA			25	- 5-	GYER.	40	5+	Ba /+	ILLA	11/1/
' ' /		31. DATE FILED (Month, Day, Year)	ECHO!	FINE				-	1	100	2	4
		WIAY U 2 1995 1"	Manual Contraction									

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

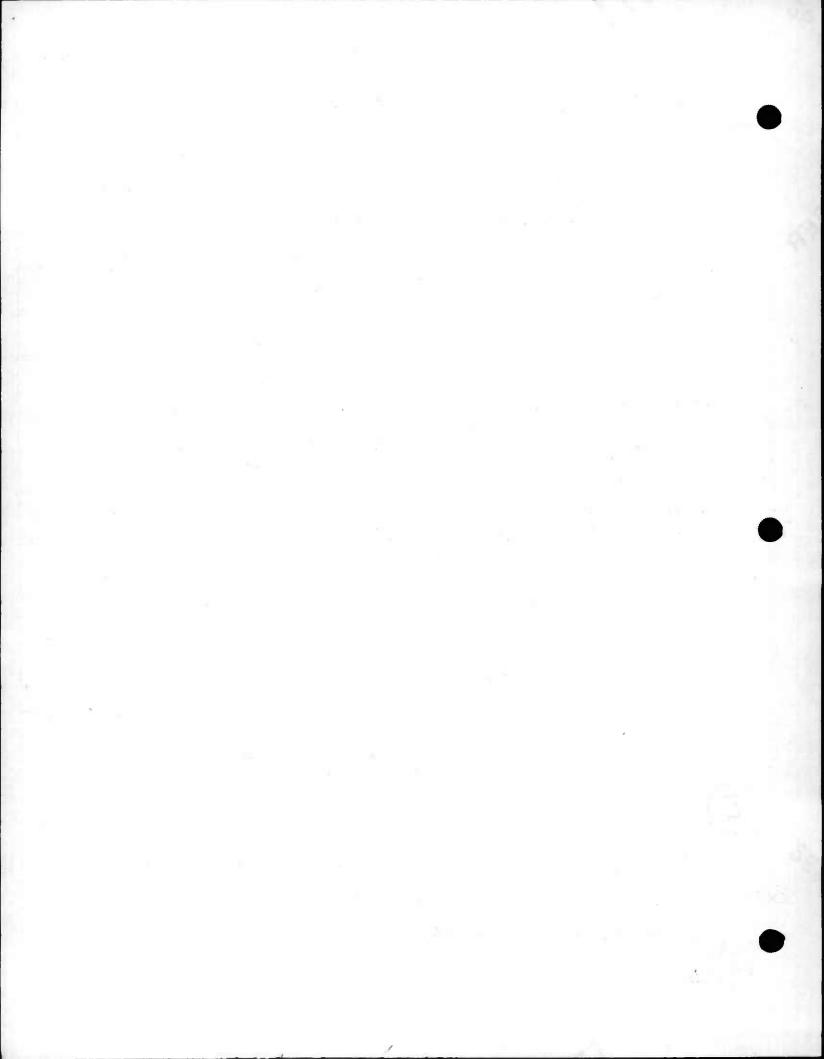
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		1 - FOR STATE REGISTRAR	STATE OF MARYL	LAND / DEPAR CERTIF	RTMENT OF	HEALTH AND	MENTAL	HYGIENE REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF MONTH	OEATH DAY	YEAR	3. TIME OF DEATH
		Anna Ther		BARAN	OWSKI		Apri		1995	5:55 a
pino		4. SOCIAL SECURITY NUMBER 215-12-5857	1 □ M 2∑ F	(In yrs. last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	April	1 % 1 5,1 9	23 Cour	THPLACE (State or Foreign Maryland
3 should	ا _ش ا	9a. FACILITY NAME (If not Institution, give. Franklin Squa		1		OR LOCATION OF E	DEATH	9c. C	OUNTY OF	DEATH
1, 2, 3	ECTOR	RESIDENCE OF DECEDENT	Te nospita		Ros	ssville		В	altim	ore
	Ä	10a. STATE 10b. COUNT	Υ	10c. CIT	Y, TOWN OR LOCA	ATION				10d. INSIDE CITY LIMITS?
permit. Pages	AL DIRE	Maryland Bal	timore		Colgate	Of, ZIP CODE		10g.	CITIZEN OF	1 TYES 2 NO
- Isr	E	Eastdale Road	7746			21224			TT 9	S.A.
21215-0020 If or attending physician. for use as the burial-transit	BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES	2V NO	If yes, s	CENDENT OF HISPA pecify Cuban, Mexic S 2 NO Spec	an, Puarto Ric	Specify Yea or No- an, etc.)	- 14, RAG	CE — American Indian, ck, White, atc. city:
215-0 attending se as the		15. DECEDENT'S EDU		16a. DECEDENT'S	USHAL OCCUPATI	ION	I see K	ND OF BUSINESS	(INDLICTORY)	White
212	COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of a life. Do NOT us	work done during m	ost of working	100. K	NO OF BUSINESS	MUUSIHT	
	AP	12	NA	Hor	ne Make	er	0,	wn Home	2	
AN the hos detach	8	17, FATHER'S NAME (First, Middle, Last)	LINE TO THE REAL PROPERTY OF THE PERTY OF TH					dle, Maiden Surnam		
RYL Md by	BE	Alexander	Ha	alley		An:	na		Wojo	czehaski
MARYLAND 212: retained by the hospital or att 5 should be detached for use notified at once.	2	19a. INFORMANT'S NAME (Type/Print)	1			and Number or Rural				
		Michele Heff]		Eltor b. Place and date		952 Ba				
TOR e 6 ma ector, p		1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	ioval from State Car	metery, crematory or o Oak La	thar placa)		OATE	20c. LOCATION		
BALTIMORE, ter death. Page 6 may be the funeral director, page wal.		21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	1 Oak Lo		ND ADDRESS OF F	ACILITY	1995 Е	astpo	oint, Md.
ALTIN death. Pag b funeral dir b. examiner		> polar G	Chenik	/		abrows				
wir z4 hours af ely filled in by nation, or remo										Approximate Interval Between Onset and Desti
	Z	Sequentially list conditions,	Metastatio			oma				ļ
3OX nte be en ysician a prior to	Ĕ	if any, leading to immediate cause. Enter UNDERLYING								
P.O. BOX 68 th certificate be executed by Hygiene prior to burian or other traumatic	RTIFICATION	CAUSE (Disease or injury that initiated avents	DUE TO (OR AS A CONSEQUENCE OF):							
P.O. h cert anding Hygie	E	resulting in deeth) LAST								į
= = =	PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY 24b. WE									
A and and	EDICAL	PART II. Other aignificant condition	is contributing to deeth b	out not resulting i	n the underlyIn	g ceuse given in		PERFORMED?	5Y 24	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH?
RECO requires th been signed t. of Health shows an	Σ	DID TOBACCO USE CONT	DIDLITE TO CALICE C	NE DEATH VE	C ET NO E	7 10 10 10 10 10 10 10 10 10 10 10 10 10				1 TYES 2 NO
12 6 8 a	SICIAN:	25. WAS CASE REFERRED TO MEDICAL	KIBUTE TO CAUSE C	26. PLACE OF DEAT			NЦ			
VITAL AN: The law tificate has le state Dept	SIC	EXAMINER?	HOSPITAL:		OTHER:	ne 5 🗆 Rasidence	a [] Other (6)			
YSICIAI Certiff	PHY	27. MANNER OF DEATH	28s. DATE OF INJURY	28b. TiM	E OF 28c. IN.	JURY AT		IBE HOW INJURY	OCCURED	
NG PHYS	BY	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ	44	YES 2 NO				
ISIO	TED	3 Suicide 8 Could not be determined	28a. PLACE OF INJURY building, etc. (Spec	28a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify)		281. LOCATION (Street and Number or Rural Route Number, City or Yown, State)			Route Number,	
DIV L OR A L DIREC Howen	1	CERTIFIER I CERTIFYING PHYS	ICIAN: To the best of my know	rledge, death occurre	d at the time, date	and place, and due	to the cause(	e) and manner as	stated.	
HOSPITAL MITHIN 72	ā		R: On the basis of exemination							a) and menner as stated.
TO THE HOSPI TO THE FUNED De filed within	2	SIGNATURE AND TITLE OF CERTIFIE	91			29c. LICENSE NU	MBER	29d. D	ATE SIGNE	D (Month, Day, Year)
E E E E	0	Mycoo				D 1848	7	•		1-95
1-1	=	30. NAME AND ADDRESS OF PERSON WH				^			-	
/()		Myo Thant, M.D.	9000 Frankl	in Squar	e Drive	Baltimo	re, MD	21237		
		31. DATE FILED (Month, Day, Year) MAY U 2 1995	32. REGISTRAR'S SON	ATT RE						
		MAI UZ 1333								



BALTIMORE, MARYLAND 21215-0020	INSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit narmin pages 1.2 3 should	, or removal,	medical examiner must be notified at once
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OF CTENDING PINSICIAN; The law requires that the death certificate be executed within 24	TO THE FUNE ALL DIRECTOR ARE THE CONTINUES DEED SIGNED by the attending physician and completely file	be fired with 72 interpretation, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT II had as marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once

	FOR 1 - STATE REGISTRAR	STATE OF MARY		RTMENT OF		MENTAL HYGIEN	_			
	1. DECEOENT'S NAME (First, Middle, Last) DEBORAH ANN BOWSES	a/k/a DELO	2. DATE OF DEATH DAY YEAR 3. TIME OF DEATH							
		1 - M XX 28 - 4	MXDGE 45 YRS. MONTHS DAYS HOURS MY		F UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTN (Morth, Day, Year) March 15, 1	a Bir	8:00 a M THPLACE (State or Foreign Instylvania		
TOR	98. FACILITY NAME (If not institution, give structure) 13654 Highland Roa RESIDENCE OF DECEMENT				OR LOCATION OF DE	EATN	9c. COUNTY OF	County		
DIRECTOR		l County		y, town on Loca Clarksvi				10d. INSIDE CITY LIMITS? 1 YES 2 NO		
FUNERAL	13654 Highland Roa	d		10	101. ZIP CODE 109. CITIZEN OF WNAT CO					
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR D	2 KNio	If yea, a	CENDENT OF HISPAN pecify Cuban, Mexica SZECIAO Specify	IIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	BI	ACE — American Indian, ack, White, etc. ectly: White		
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	ATION ompleted) College (1-4 or 5+) 5+	16a. DECEDENT'S (Give kind of life. Do NOT u	USUAL OCCUPATI work done during manage retired.)	ON osl of working	Johns H	siness/inoustry Hopkins & Labora	Applied		
Ö	17. FATHER'S NAME (First, Middle, Last)				18, MOTHER'S NA	ME (First, Middle, Maiden				
BE	Merle L. B	owser	_			Shaeffer				
10	Mr. W. G. "Jerry"	Bath				Clarksvil		rland 21029		
	Mr. W. G. "Jerry" Bath  13654 Highland Road, Clarksville, Maryland 21029  20s. METNOD OF DISPOSITION 1206 PLACE AND DATE of DISPOSITION (Name of competent, elemetory or other place) Linchicum Chapel Cametery 4-29-95 Clarksville, Maryland 21. SIGNATURE OF PURE RAL SERVICE LICENSEE  20s. PLACE AND DATE of DISPOSITION (Name of competent of Special Place) Linchicum Chapel Cametery 4-29-95 Clarksville, Maryland 22. NAME AND ADDRESS OF FACILITY Slack Funeral Home, P.A.									
Ш	Mumbeller	186	M0053	5 E11	icott Ci	ty, Maryla	and 2104	3		
	23. PART I. Enter the diseases, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death disease or condition a. Due to (or as a consequence of):									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in death) LAST									
8	PART II. Other significant conditions contributing to death but not resulting in the underlying cause gives in Section 1.									
MEDICAL	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED?  1 YES TO NO  24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES TO NO									
AN	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL	BUTE TO CAUSE C	26. PLACE OF OEA		UNCERTAIN	10				
SICI	EXAMINER?	HOSPITAL:		OTHER:	Residence					
BY PHYSICIAN:	27. MANNER OF DEATN  1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	26b. TIM	E OF 28c. INJ		28d. DESCRIBE NOW II	NJURY OCCURED			
ED.	3 Suicide 6 Could not be determined	28e, PLACE OF INJURY building, etc. (Spe-	f — At home, ferm, city)	street, factory, offic	•	26f. LOCATION (Street a City or Town, State)	and Number or Rura	l Route Number,		
COMP	29s. CERTIFIER (Check only one)  1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and dus to the cause(s) and menner as stated.  2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.									
O BE	29b. SIGNATURE AND TITLE OF CERTIFIER  30. NAME AND ADDRESS OF PERSON WHO	M	ly.	no	29c. LICENSE NUM	BER S	29d. DATE SIGNE	ED (Manth, Day, Year)		
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGN	1811	Print)	na Ph	who Or	, 0/re-	timo		
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DIRECTOR: A hours after c .00

hours after death. Page 6 may be retained by the hospital or attending physician.

BALTIMORE, MARYLAND 21215-0020

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-723 5/5/95 t.t 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY 3. TIME OF OFATH YEAR LARRY BROOKS APRIL 95 :14P 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 1 X M 2 T F 30 DAYS HOURS MIN. 217-88-1507 11-2-1964 Maryland 99. FACILITY NAME (If not institution, give street and number) 3212 BRENDEN AVENUE 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR BALTIMORE CITY Baltimore City RESIDENCE OF DECEDENT 10e. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore City Baltimore 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 3212 Brendan Ave 21213 USA 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
 If was, specify Cuben, Mexican, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO 14. RACE — American Indian, Black. White, etc. 1 Never Married 2 X Married If yes, specify Cube

1 YES 2 X NO IF YES, GIVE WAR OR DATES Specify: BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION secify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most citie. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Soc Elementary/Secondary (0-12) College (1-4 or 5+) Service Technician Cummins - Wagner 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Clifford H Brooks Phyllis Ann Banhoose BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Cathy Brooks 3212 Brendan Ave Baltimore, Md 21213 20e METHOD OF DISPOSITION
143 Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State tory or other plece)
Hill ☐ Donetion 6 ☐ Other (Specify) Holly Memorial 5-3 Baltimore, Md 21. SIONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Dundalk 01 7110 Sollers Point Rd 23. PART I. Enter the diseases, or complications that caused the death, shock, or heart sillure. List only one cause on each line. Dø ot antar the mode of dying, such as cardiac or respiratory screet, Approximata Interval Between IMMEDIATE CAUSE (Fine) Onset and Death disesse or condition_ NARCOTIC INTOXICATION resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not reaulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \( \Boxed{1}\) NO \( \Boxed{1}\) UNCERTAIN \( \Boxed{1}\) PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) EXAMINER? HOSPITAL: OTHER: 1 Inpatient 2 I ER/Outpatie 4 - Nursing Home 5. Residence 8 - Other (Specify) 27. MANNER OF OEATH 26e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 26d. OEŞCRIBE HOW INJURY OCCURED 1 Natural 5 Pending UNKNOWN FOUND ON 4/28/95 PM 1 YES 2 NO 1:14 BY Investigation 2 Accident 26e. PLACE OF INJURY — At home, term, street, tactory, office building, atc. (Specify) 3 Suicide 26t. LOCATION (Street and Number or Bural Boute Number, City or Town, State) 3212 BRENDEN AVE. ED 6 XX Could not be 4 Homicide FOUND AT HOME COMPLET 29e. CERTIFIER 1 _ CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end manner es stated. XX MEDICAL EXAMINER: On the basis of exa ation end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(s) end menner as stated. 29b. SIGNATURE AND THILE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE O.C.M.E. APRIL 30/95 2

111 PENN STREET, BALTIMORE, MARYLAND

DIVISION OF VITAL RECORDS, P.O. BOX 68760 requires that the DR ATTENDING PHYSICIAN: The law TO THE HOSPITAL TO THE FUNERAL (De filed within 72 h HOSPITAL

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Powler

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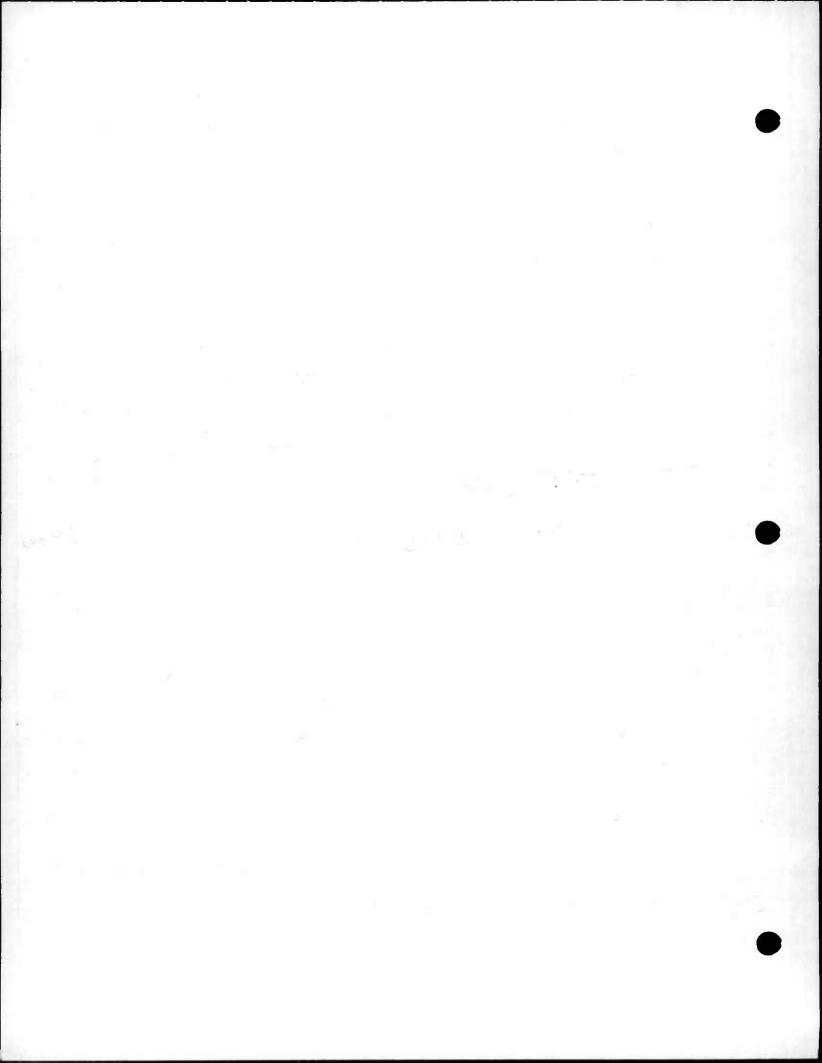
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remains.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTME	NT OF HEALTH AND	MENTAL HYGIENE
CERTIFICA	TE OF DEATH	REG NO

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, La	ast)					E OF DEATH			3. TIME OF DEATH
	John Keiler Bri	an, Sr.		100			April 24, 1995			8 P. M
1	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH			PLACE (State or Foreign
	218-14-2716	/ Y YRS.	ONTHS DAYS	HOURS MIN.				WAS	HINGTON, DC	
Or I	9a. FACILITY NAME (If not institution, gl				R LOCATION OF D	EATH		9c. COUN		
<u>ō</u>	12871 Highland	Road		High	land			Ho	owar	d
DIRECTOR	10a. STATE 10b. COU		10c. CITY,	TOWN OR LOCAT	ION					10d. INSIDE CITY
5	Maryland H	oward		High	land					LIMITS?
AL	10e. STREET AND NUMBER			101.	ZIP CODE			10g. CITI2	EN OF W	HAT COUNTRY?
FUNERAL	12871 Highland	Road			20777				US	A
ä	11. MARITAL STATUS	12. WAS DECEDENT EVER I FORCES? 1 YES	N U.S. ARMED	13. WAS DEC	ENDENT OF HISPA	NIC ORIGI	N? (Specify Ye	s or No-	14. RACE	— American Indian, , White, atc.
ВУ	1 Never Married 2 Married  3 Wildowed 4 Divorced	IF YES, GIVE WAR OR D	ATES ATES		elfy Cuban, Maxic 2 NO Speci		Rican, etc.)			y:White
	15. DECEDENT'S 8	- I	r	<u> </u>						
COMPLETED	(Specify only highest gr	rade completed)	16a. DECEDENT'S US (Give kind of wor life. Do NOT use	k done during mo:	N at of working	16	b. KIND OF BU	SINESS/INDL	JSTRY	
7	Elementary/Secondary (0-12)	College (1-4 or 5+)	Owner	earea.)			Even	vating	· Co	mn any
N N	17. FATHER'S NAME (First, Middle, Last)	P	Owner		18. MOTHER'S NA				3 00	шрапу
	John Keiler Bri				Mildre			,		
B	19a. INFORMANT'S NAME (Type/Print)	an	10h MAILING A	DDBESS /Street a	nd Number or Rural				0.41	
2	E. Esther Brian				d Road,					20777
	20s. METHOD OF DISPOSITION 1 Burlai 2 Cremation 3 R		. PLACE AND DATE OF				TE _20c. LO			
	1 N Burlet 2 Cremation 3 R 4 Donation 5 Other (Specify)	lamoval from Stata con	netery, cremetory or othe Zion Me	r placa)	Ch. Cer	m 41.2	145 H			Maryland
	21. SIGNATURE OF FUNERAL SERVICE		DIOII III							ome, Inc.
1	160000	Di Wall								MD 20707
$\neg$	23 PADT   Enter the dispasse	To complication and dis-	date death De ser		•	•			-	
	23. PARTAL Enter the diseases or complications that gaussion each line.  Approximate interval Between Onset and Death disease or complications that gaussion each line.  Approximate interval Between Onset and Death disease or condition resulting in desth)									
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):									
₹	PERFORMED? A							WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
MEDIC								-5-		1 TES 2 NO
ż	DID TOBACCO USE CON		F DEATH YES	□ NO 🛱	UNCERTAI	N				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF DEATH							
YSI	1 TES 2 NO	1 - Inpatient 2 - ER/Outs		THER:  Nursing Home	5 Rasidenca	6 🗆 Oth	er (Specify)			
표	27. MANNER OF DEATH  1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME (		RY AT	28d. DE	SCRIBE HOW I	NJURY OCC	JRED	
Β¥	1 Natural 5 Pending 2 Accident investigation			ES 2 NO						
		3 Suicide 6 Could not be 28s. PLACE OF INJURY — At home, tarm, street, factory, office 28s. LOCATION (Street and Number or Rural Route Number, building, etc. (Specify)								oute Number,
SIGNATURE AND TITLE OF CERTIFIAN  5 Could not be detarmined  6 Could not be detarmined  5 Could not be detarmined  6 Could not be detarmined  6 Could not be detarmined  6 Could not be detarmined  6 City or Town, State)  29a. CERTIFIER (Check only one)  2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and placa, and due  29b. SIGNATURE AND TITLE OF CERTIFIAN  29c. LICENSE NUMBER  29c. LICENSE NUMBER										and manner as stated
H	8.11	delin.	***	17.	025	94.5	1	ZVG. DATE	Ja	(Month, Day, Year)
유	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF DE	ATH (ITEM 27) /Type Pr	int)	V - J	16		7	1 1-3	///
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	MAY 0 2 1995	William And Stone	RE							



BOX 68760 DIVISION OF VITAL RECORDS, P.O.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Lillian Sherman Bushlow YEAR 23. 1995 Apr. 12:30 a.m.m 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign DAYS HOURS 12, 1 M 2 X F 67 578-28-9418 May Washington, DC. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give atreet and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 12812 Camellia Drive Silver Spring Montgomery RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Montgomery Silver Spring 1 YES 2 NO permit. FUNERAL 10e STREET AND NUMBER 101, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? page 5 should be detached for use as the burial-transit 12812 Camellia Drive 20906-3316 USA hours after death. Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yea, specify Cuben, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 14. RACE - American Indien, Bleck, White, etc. BALTIMORE, MARYLAND 21215-0020 2 X NO 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced Specify: white COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY most of working ry/Secondary (0-12) College (1-4 or 5+) 12 0 Clerk Retail 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Harry Sherman ¥ Rochelle Abramowitz BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Elliott Bushlow 12812 Camellia Drive, Silver Spring, Md. 20906-3316 3 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must 20s. METHOD OF DISPOSITION

1 □ Burlel 2 □ Cremation 3 □ Removal from State

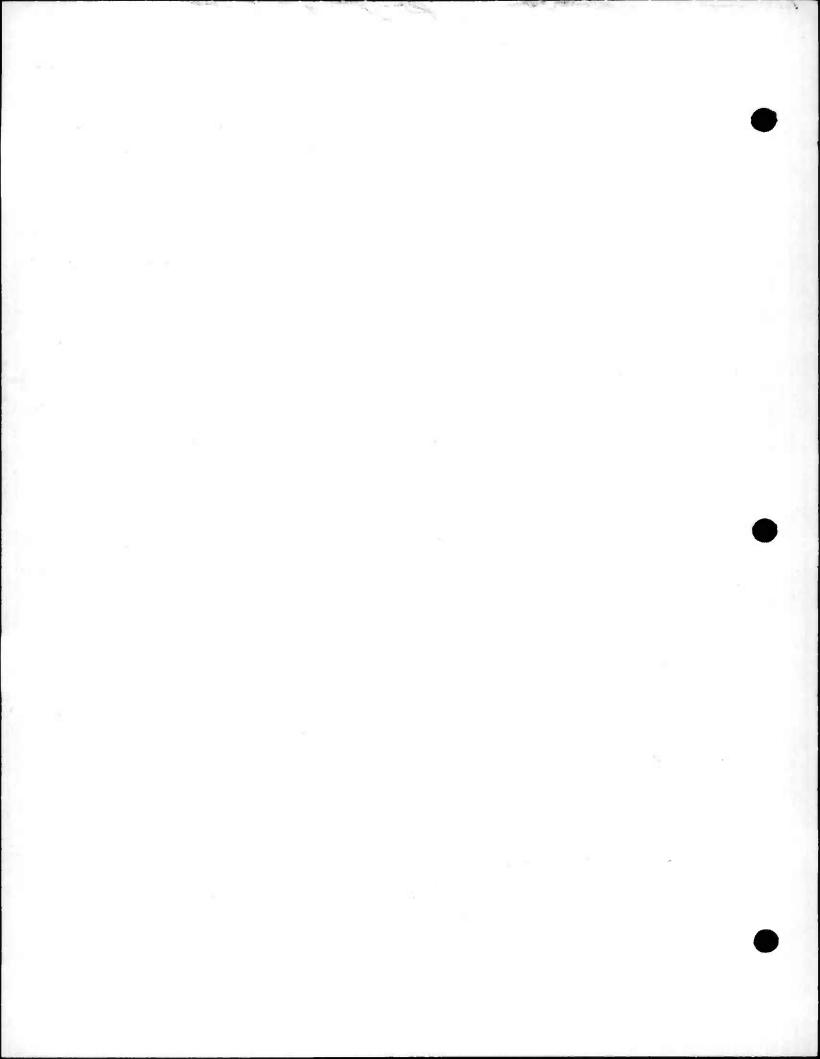
4 □ Donation 8 □ Other (Specify) funeral director. Baltimore-Wash. Crematory 4/23 Laurel, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSES examiner 22. NAME AND ADDRESS OF FACILITY Fleck Funeral Home, Inc. n by the fu 7601 Sandy Spr. Rd. Laurel, Md. 20707 medical filled in by 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, Approximate ahock, or haart failure. List only one cause on each line. Interval Between 6 **IMMEDIATE CAUSE (Final** Onset and Dasth the cremation. disease or condition resulting in death) to bunal, cremation Martane Carcinona event. DUE TO (OR AS A CONSEQUENCE OF): traumatic mong CERTIFICATION Sequentially list conditions. 2 DUE TO (OR AS A CONSEQUENCE OF) If sny, leading to immediate the attending physician I Mental Hygiene prior to that the death certificate be cause. Enter UNDERLYING CAUSE (Disesse or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a, WAS AN AUTOPSY n signed by the Health and N 24b. WERE AUTOPSY FINDINGS to any codyplana PERFORMED? AVAILABLE PRIDE TO COMPLETION OF CAUSE amy due 1 TYES 2 NO requires 1 OF DEATH? Shows 1 TES 2 NO been : DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES INO W UNCERTAIN I OR ATTENDING PHYSICIAN: The faw DIRECTOR: After this certificate has bhours after death with the State Dept. S 25. WAS CASE REFERBED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item certificate h HOSPITAL OTHER: 1 TYES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 N Residence 8 □ Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) marked. 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending M 1 YES 2 NO ВУ 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 COMPLETED 8 Could not be 4 Homicide 29a, CERTIFIER 1 📈 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) FUNERAL within 72 h = HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(a) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7. 286. SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER 29d, DATE S GNED (Moeth, Day, Year) H 2  $\mathfrak{F}\mathfrak{O}$ 9 2 OF DEATH (ITEM 27) (7/4

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<b>BALTIMORE, MARYLAND 21215-00</b>	or attending p
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burial-transit physician.

page 5 should be detached for use as the

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,  TO THE HOSPITAL OF ATTACHMENT THE law requires that the death certificate be executed within 24 hours after death. P  TO THE FUNERAL DIRECTOR WE INCOME. The law requires that the death certificate be executed within 22 hours and completely filled in by the funeral be filed within 72 hours and the fatte Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  IMPORTANT: If item to be marked on New 23 shows any Injury, or other traumatic event, the medical examin.	BALTI	hours after death. P	ed in by the funeral or removal.	medical examin
	DIVISION OF VITAL RECORDS, P.O. BOX 68760.	TO THE HOSPITAL OR ATTENDED SYNSICIAN: The law requires that the death certificate be executed within 24 hours after death, P	TO THE FUNERAL DIRECTOR, over the combetely filed by the attending physician and completely filed within 72 mountains one. The filed within 72 mountains one filed within 72 mountains one.	MPORTANT: If them to is marked, or item 23 shows any Injury, or other traumatic event, the m

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle | nat) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR 4 A. **JEROME** BERKOWITZ 1995 25, APR. 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Dey, Year) FEB 25, 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign 90 058-09-2369 1 X M 2 | F DAYS HOURS 1905 FRANCE 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH BALTTMORE NORTHWEST HOSPITAL CENTER RANDALLSTOWN DIRECTOR RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE RANDALLSTOWN YES 2 NO FUNERAL 10e STREET AND NUMBER 10f. ZIP CODE 21133 10g, CITIZEN OF WHAT COUNTRY? 9109 LIBERTY RD. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuban, Maxican, Puerio Rican, atc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Merried Specify WHITE 1 TES X NO Specify: B 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) PRINTER PRINTING 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surneme) SARAH WECHSLER BERKOWITZ MAX BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MR. LEWIS BERKOWITZ 627 LEAFYDALE TERRACE BALTO., MD 21208 Pts. METHOD OF DISPOSITION

The Buriel 2 Cremation 3 Ren

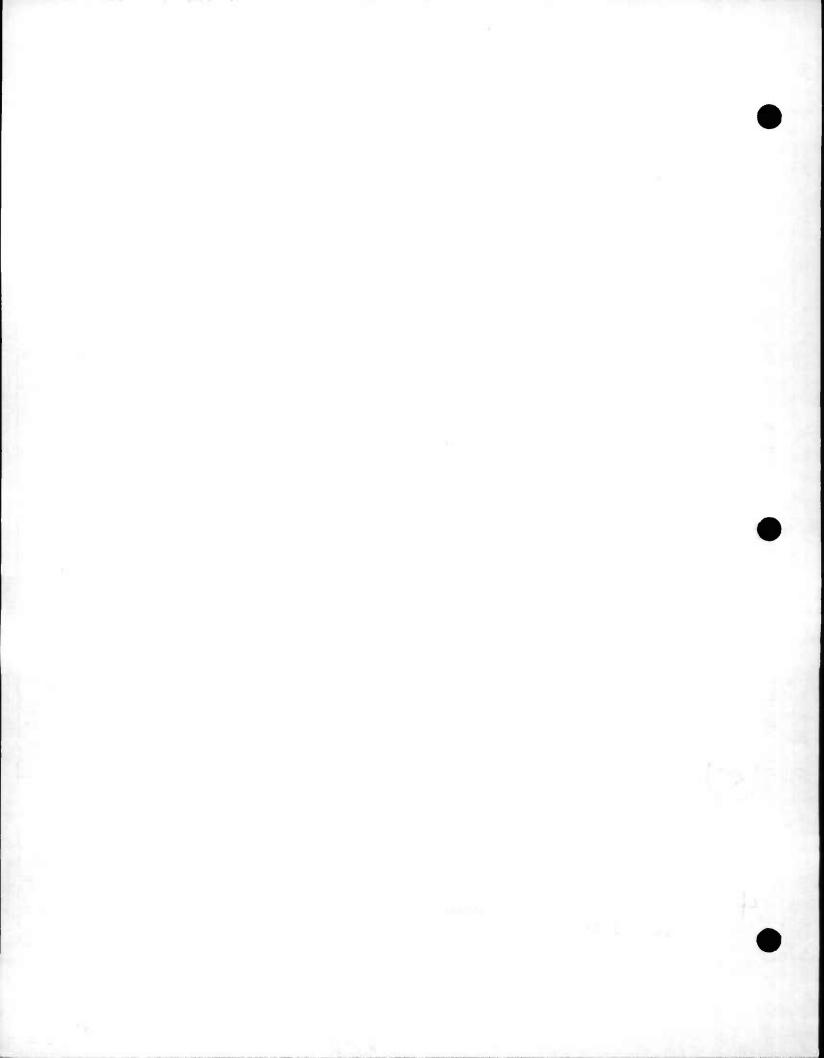
The Donation 5 6 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State MÍKRO KODESH-BETH ISRAEL 4/28/95 BALTIMORE, MD 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. reco 6010 REISTERTOWN RD. BALTO., MD 21215 23. PART V. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart lailure. List only one Interval Bety IMMEDIATE CAUSE (Finel Onset and Death disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but net resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 1 TES 2 TOU OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO INCERTAIN I PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER: 1 YES 2 NO 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Gould not be 4 🗌 Homicide COMPLET 29a, CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) end menner ee stated. 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)
APRIL 25, 1995 BE 2 ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 30. NAME AND

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Resin



1. DECEDENT'S NAME (First, Middle, Last)

FRANKLIN

REG. NO.

DAY 2 6

2. DATE OF DEATH

APRIL

Item # 20b Film # g 723 5-2-95 N.A. Per Funeral Home FOR STATE REGISTRAR

В.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

BRANNAN

4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs, last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) Nov. 29, 1929 HOURS 217-26-2463 1 X M 2 F 65 YRS use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 1116 RIVERSIDE AVE. BALTIMORE City RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION none 1116 Riverside Ave. Balto, City Maryland 10s. STREET AND NUMBER FUNERAL Riverside Ave. 1116 21230 retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 ∑ YES 2 □ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-BALTIMORE, MARYLAND 21215-0020 1 X Never Married 2 Married If yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: BY 3 Widowed 4 Divorced Korean 15. DECEDENT'S EDUCATION 6 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe ET College (1-4 or 5+) ō Elementary/Secondary (0-12) COMPL 1st.National Bank none Security Guard detached 8th.Grade 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Brannan 2 7 Michael BE page 5 should notified 19e. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Rown, State, Zin Code) 1136 Riverside Ave.Balto.Md. 21230 2 Marguerite Gardiner nours after death. Page 6 may be must be 20c. LOCATION — City or Town, State 20s. METHOD OF DISPOSITION Cedal ATTPECE Cemetery, 4/26/9 20b. PLACE AND DATE OF DISPOSITION (Name of ty Burlet 2 Cremation 4 Donation 5 Other (Specify) funeral director, examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Balto.Md.21230 McCully Funeral Home, 130 E.Fort Ave There nding physician and completely filled in by the Hygiene prior to burial, cremation, or removal. the medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heert failure. List only, IMMEDIATE CAUSE (Final disease or condition DUE TO BH AS A CONSEQUENCE OF): reaulting in death) traumatic event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed COURSC CERTIFICATION Sequentially list conditions, if any, leading to immediate signed by the attending physician Health and Mental Hygiene prior to cause. Entar UNDERLYING other CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted eventa resulting in death) LAST 5 any injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO 23 shows has been s Dept. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL this certificate has with the State C irked, or Item Hem **EXAMINER?** HOSPITAL: OTHER: 1X XYES 2 □ NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4 - Nursing Home XXReeldence 8 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED is marked, Natural Accident 1 YES 2 NO DIRECTOR: After the hours after death v BY Investigation 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) a Could not be determined COMPLETED 28 4 Homicide Hem 29a CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner es stated. FUNERAL I within 72 h TANT: If I TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 18 2 K MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner as stated. ATURE AND TITLE OF CERTIF 29c. LICENSE NUMBER BE O.C.M.E. 2 HO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND 21201

1995

3. TIME OF DEATH

1:05P

10d. INSIDE CITY LIMITS?

1 YES 2 NO

Approximate

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE

1 - YES 2 NO

OF DEATH?

Intarval Betwe

Onset and Death

a. BIRTHPLACE (State or Foreign

Maryland

10g. CITIZEN OF WHAT COUNTRY?

United States

14. RACE — American Indian, Black, White, etc.

SpecMy: White

9c. COUNTY OF OEATH

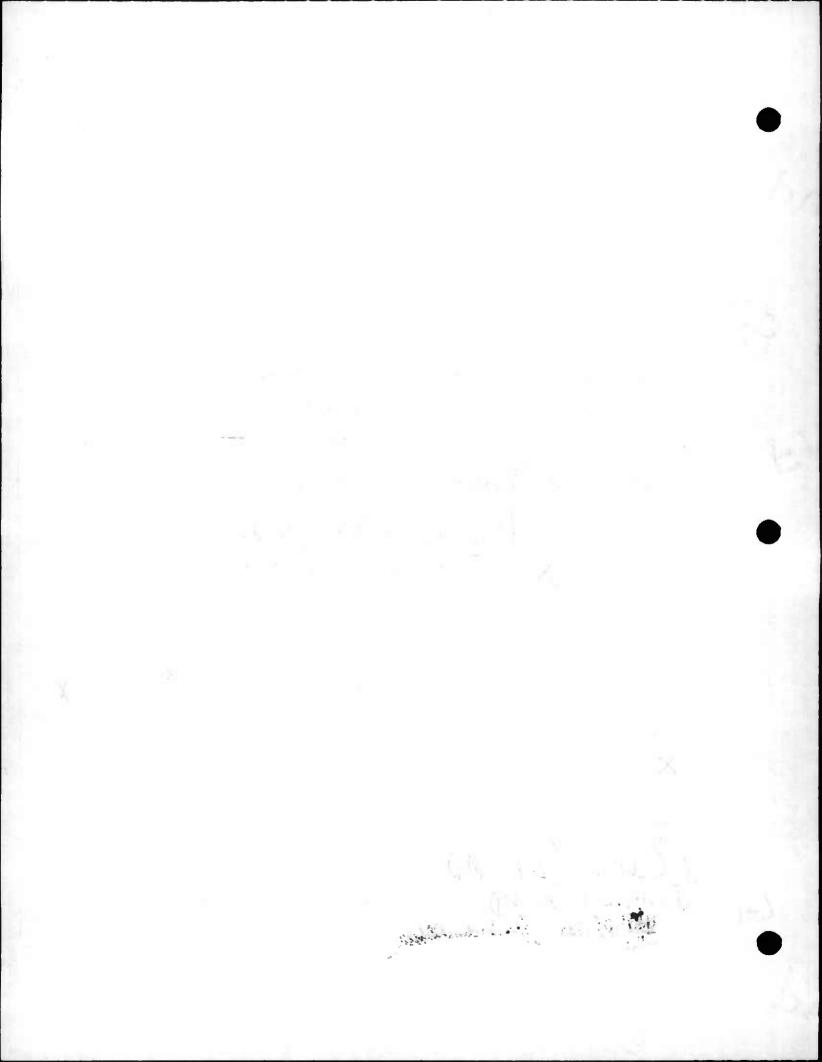
none

Harvey

A.A.Co.Md.

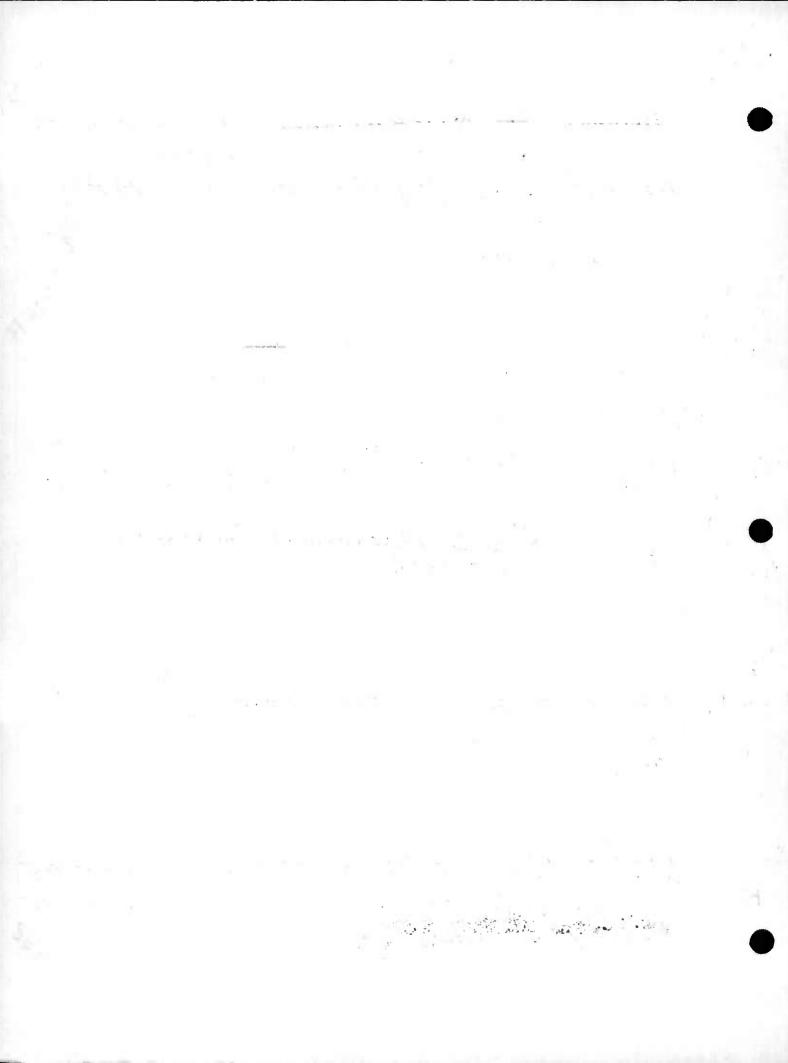
29d. DATE SIGNED (Month, Day, Year)

APRIL 27/95



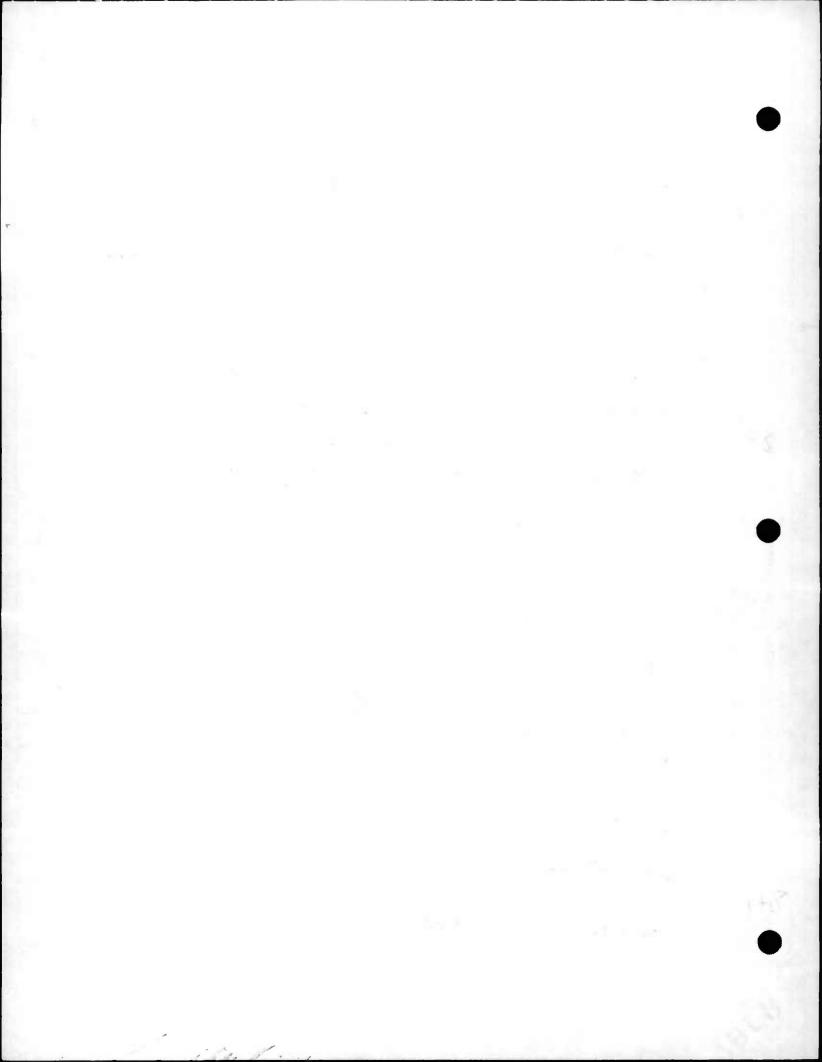
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	THE THE	TO THE	4
	K	)	

		1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO.
	8	1. DECEDENT'S NAME (First, Middle, Last)  Thomas Brenneman  2. Date of Death MONTH  DAY  YEAR  0205 M
70		4. SOCIAL SECURITY NUMBER 212-40-4588  5. SEX 6. AGE (In yrs. last birthday) 1 MM 2 F 5. SEX 1 MONTHS DAYS HOURS MIN.  7. DATE OF BIRTH (Month, Day, Year) 1 MN 2 MN 2 MN MONTHS DAYS HOURS MIN.  8. BIRTHPLACE (State or Foreign Country) Mary I and
, 2, 3 should	TOR	98. FACILITY NAME (If not institution, give street and number)  North Arundel Hosp Glen Burnie A,  RESIDENCE OF DECEDENT
020 physician. burlat-transit permit. Pages 1,	DIRECTOR	100. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS?  1 □ YES 2 X X NO
in. ansit pern	FUNERAL	100. STREET AND NUMBER 734 Whitney's Landing Drive 101. ZIP CODE 21032 USA
9 ig 9	BY	11. MARITAL STATUS  1 Never Merried 2 Merried 3 Wildowed 4 Divorced  12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 10 II YES, give War or Dates  13. Was DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—II yes, specify Cuben, Mexican, Puerto Ricen, atc.)  14. RACE — American Indian, Black, While, atc.  15. WAS DECEDENT EVER IN U.S. ARMED II yes, specify Cuben, Mexican, Puerto Ricen, atc.)  16. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—II yes, specify Cuben, Mexican, Puerto Ricen, atc.)
21215 al or attend for use as	TED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use perfect)  16b. KIND OF BUSINESS/INDUSTRY
	COMPLETED	Ret. Assembly Line Wroker General Motors
_ ≥ å €	BE CO	12. FATHER'S NAME (First, Middle, Last) Luther Edwyn Brenneman Irene Beatrice Clough
	10	196. INFORMANT'S NAME (Type/Print)  196. MAILING ADDRESS (Street and Number or Aural Pouts Number, City or Town, State, Zip Code)  196. MAILING ADDRESS (Street and Number or Aural Pouts Number, City or Town, State, Zip Code)  506 Oakwood Rd., Glen Burnie, Md. 21061
AORE, te 6 may be rector, page must be		20e, METHOD OF DISPOSITION 1 (X Burlel 2 Cremellon 3 Removal from State deposition (Name of Commellon 5 Other (Specify)  20b. PLACE AND DATE Of DISPOSITION (Name of Commellon 5 Other (Specify)  20c. LOCATION - City or Town, State Of Part of Commellon 5 Other (Specify)  20c. LOCATION - City or Town, State Of Part of Commellon 5 Other (Specify)  20c. LOCATION - City or Town, State Of Commellon 5 Other (Specify)
BALTIMORE, after death. Page 6 may be y the funeral director, page moval.		21. SKNATURE OF FUNERAL SERVICE LICENSEE Kevin E. Ecker  McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225
be executed with cours cian and completely filled in the fort to burial, cremation, or refraumatic event, the media	ATION	23. PART I. Entar tha diseasas, or complications that caused the death. Do not entar the mode of dying, such as cardiac or reapiratory errest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition)  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):
P.O. th certific ending p il Hygiena or othe	CERTIFICATION	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):  resulting in death) LAST  d.
RECORDS v requires that the d been signed by the t. of Health and Me shows any Injun	MEDICAL	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i.  24a. WAS AN AUTOPSY PERFORMED?  1 VES 2 NO  24b. WERE AUTOPSY FINDINGS ANALIABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 VES 2 NO
T # 8 8 E	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1 DES 2 NO  1 Inpatient 2 FR/Oulpatient 3 DOA  4 Nursing Home 5 Residence 8 Other (Specify)
OF PHYSIC this cer with th	ВУ РНУ	27. MANNER OF DEATH  1 Netural 5 Pending (Month, Day, Year)  28. DATE OF INJURY (Month, Day, Year)  28. DATE OF INJURY 28. TIME OF INJURY WORK?  1 YES 2 NO  28. DATE OF INJURY AT WORK?
DIVISION OR ATTENDING I DIRECTOR: After hours after death item 28 is man	ETED E	3 Suicide 8 Could not be 4 Homicide detarmined 28e. PLACE OF INJURY — At home, tarm, street, factory, office building, etc. (Specify) 28l. LOCATION (Street and Number or Rural Route Number, City or Town, State)
₹ 4 2 <b>=</b>	COMPLE	29s. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the beet of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as attend.  2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner se stated.
TO THE HOSPI TO THE FUNER be filed within	TO BE	296. SIGNATURE AND TITLE OF CERTIFIED  Deputy  29c. LICENSE NUMBER  29d. DATE SIGNED/(Month, Day, Year)  TOGOS4  4/25/45  30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
0		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  William P. Jones, MD 695 America 21035  31. DATE FILED (Month, Day, Year)  32. REGISTRAR'S SIGNATURE
		MAY 02 1995 July Studen Rail 18
		DHMH-16 Rev 1/89



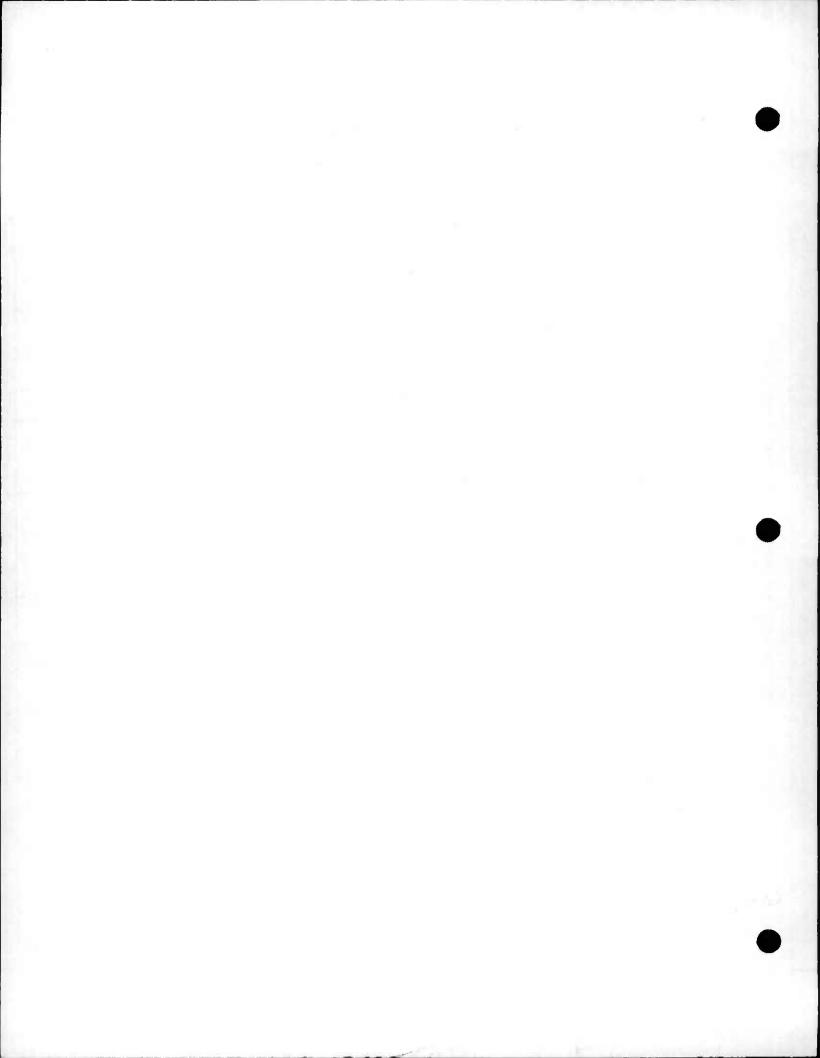
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		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPA	RTMENT OF	HEALTH AND N	MENTAL HYGIEN	E	
		1. DECEDENT'S NAME (First, Middle, Last)  TOSEPH R	OBERT B.				2. DATE OF DEATH DA APRIL 2		3. TIME OF DEATH  5:10 Pm
273		4. SOCIAL SECURITY NUMBER 214–18–1891	5. SEX 6. AGE	(In yrs. last birthday 72 vrs.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH September 12	6. BIRTH	NPLACE (State or Foreign aryland
020 physician. burial-transit permit. Pages 1, 2, 3 should	OR	90. FACILITY NAME (If not institution, give St. Agnes Hospital	street end number)		96. CITY, TOWN Baltimore	OR LOCATION OF DEA		9c. COUNTY OF D	DEATN
	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT Maryland Bal	timore		ITY, TOWN OR LOCA	ITION			10d. INSIDE CITY LIMITS?
sit permit.		100. STREET AND NUMBER 210 W. Elpin Drive			111111	H. ZIP CODE 21228		10g. CITIZEN OF V	
215-0020 attending physician. ise as the burial-tran	BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 V YES IF YES, GIVE WAR OR D	IN U.S. ARMED 2 NO DATES	If yes, s	CENCENT OF NISPANI pecify Cuben, Mexican 8 2 NO Specify:	C ORIGIN? (Specify Yea , Puerto Rican, etc.)	or No— 14. RACI Bleck Spec	E — American Indian, k, White, elc.
BALTIMORE, MARYLAND 21215-0020 or death. Page 6 may be retained by the hospital or attending physic the funeral director, page 5 should be detached for use as the burial val.	COMPLETED	15. DECEDENT'S EDI (Specify only highest grad Elementery/Secondary (0-12)		160. DECEOENT (Give kind o life. Do NOT Sales Ma	s usual occupation of work done during mouse retired.)	ON ost of working	166. KIND OF BUS	SINESS/INOUSTRY	
MARYLAND 21; retained by the hospital or 5 should be detached for u notified at once.	BE CON	17. FATNER'S NAME (First, Middle, Last) John R. Bishop				Minerva	IE (First, Middle, Melden : Schwartz		
be retained by the 5 should be notified at	10	190. INFORMANT'S NAME (Type/Print) Shirley E. Bishop					oute Number, City or Town		
MORE, I ge 6 may be i director, page 5 ir must be n		264. METNOD OF DISPOSITION 1 Burlel 2 Cremation 3 Ren 4 Donation 6 Other (Specify)	noval from State	b. PLACE AND DATI New Cathed	of disposition (N. other place)	ry May 1	, 1995 Balt	cation — city or to timore, MD	
BALTIMORE, hours after death. Page 6 may be ed in by the funeral director, page or removal. medical examiner must be		21. SIGNATURE OF FUNDAMENTAL SURVICE LI	CENSEE	Le le	Leroy 1	M. & Russel dmondson Ave	l C. Witzke I e Caatonsvill	Funeral Hor le. MD 2122	ne 28
within z4 hours aff within z4 hours aff ppletely filled in by cremation, or remo rent, the medica		23. PART I. Enter the diseases, or shock, or heart failure.  IMMEDIATE CAUSE (Finsi disease or condition resulting in death)	. Metast	each line.	not enter the mo	ode of dying, such	es cardiac or respir	ratory srrest,	Approximate interval Between Onset and Death
certificate be executed ding physician and chygiene prior to burian other traumatic	CERTIFICATION	Sequentially list conditions, if smy, leading to immediate ceuse. Enter UNDER/LYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	с	A CONSEQUENCE					
RECORDS, P w requires that the death been signed by the atter pt. of Health and Mental if 3 shows any Injury, o	MEDICAL CE	PART II. Other significant condition  Perforated	dnodena	1 41	cers	g ceuse given in P	Part I. 24e. WAS AN PERFORI	MEO?	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION DF CAUSE DF DEATH?  1 YES 2 NO
- % & & ~ l	SICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	RIBUTE TO CAUSE O		ATN (Check only one) OTHER:	UNCERTAIN			
OF VITA OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate h rours after death with the State E tem 28 is marked, or litem	РНУ	1 VES 2 NO  27. MANNER OF DEATN  1 Netural 5 Pending Investigation	26e. DATE OF INJURY (Month, Day, Year)	28b. TI	4 Nursing Hom ME OF 26c. IN.	Ne 5 Residence 6 JURY AT DRK? YES 2 NO	Other (Specify)  26d. DEŞCRIBE NOW IN	JURY OCCURED	
DIVISION OR ATTENDING I DIRECTOR: After hours after death item 28 is man	ETED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	26e. PLACE OF INJURY building, etc. (Spec	f — Al home, farm,	street, factory, offic	•	281. LOCATION (Street as City or Town, State)	nd Number or Rural R	Route Number,
DIV THE HOSPITAL OR A THE FUNERAL DIREC filed within 72 hours PORTANT: If Item	COMP		ICIAN: To the best of my know ER: On the beele of examination						i) and manner ee stated.
TO THE HOSPITAL TO THE FUNERAL ( be filed within 72 h IMPORTANT: If i	) Je	SUMMATURE AND TITLE OF CERTIFIE	ayrand			DY18		29d. DATE SIGNED	(Month, Day, Year)
Sti		30. NAME AND AGORESS OF PERSON WE	tre	Balt.	e, Print)	>			
		31. DATE FILEO (Month, Day, Year) WAY U 2 1995	32. REGISTRAR'S SIGN	al l					



OHMH-18 Rev 1/89

		1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO.
		1. DECEMBENTS NAME (#STE. MOSSin, Last)  2. DATE OF DEATH MOSTIN LAST)  2. DATE OF DEATH MOSTIN LAST)  2. DATE OF DEATH MOSTIN LAST)
		4. SOCIAL SECURITY NUMBER 5. SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (In SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN SEX. 8. AGE (IN S
pio		13090338   1502 = 1
2, 3 should	OB	Summit Nursing Home Catonsville Baltimore
Pages 1,	DIRECTOR	RESIDENCE OF DECEDENT  10e. STATE  10b. COUNTY  10c. CITY, TOWN OR LOCATION  10d. INSIDE CITY
permit. Pa		Maryland Baltimore Catonsville LIMITS?  100. STREET AND NUMBER  100. STREET AND NUMBER
- ISI	FUNERAL	5721 Edmondson Avenue C-2 101. ZIP CODE 109. CITIZEN OF WHAT COUNTRY? U.S.A.
215-0020 attending physician. se as the burlal-transit	BY FUR	11. MARITAL STATUS  1 Never Merried 2 Merried 2 Merried 3 Widowed 4 Divorced  12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 XYES 2 NO IF YES, GIVE WAR OR DATES  13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-Bleck, White, etc.)  14. RACE — American Indian, Bleck, White, etc. Specify: White
21 21 20 m	COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementery/Secondary (0-12)  College (1-4 or 5 +)  18e. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  18b. KIND OF BUSINESS/INOUSTRY
AND the hospital detached fo	OM	12 Payroll Clerk Mill  17. FATHER'S NAME (First, Middle, Last)  18. MOTHER'S NAME (First, Middle, Melden Surname)
# 2 4 K	BE	Ephriam T. Burgee Anna M. Englehart  190. INFORMANT'S NAME (Type/Print)  190. MAILING ACCRESS (Street and Number or Firm) State Via Code)
	5	Mary M. Burgee (Spouse) 5721 Edmondson Avenue Catonsville, Maryland 21228
ALTIMORE, leath. Page 6 may be funeral director, page xaminer must be		20e. METHOD OF DISPOSITION  1 Notice   2 Cremetion   3 Removal from State   20b. PLACE AND DATE OF DISPOSITION (Name place)   May   1, 1995   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c. LOCATION - City or Town, State   20c.
BALTIMOR er death. Page 6 mar the funeral director, p val.		22. NAME AND ADDRESS OF FACILITY  Leroy M & Russell C Witzke Funeral Homes
0 = 0		1630 Edmondson Avenue Catonsville Maryland
within 24 hours within 24 hours operation, or recemble or recemble.		Approximats interval Between shock, or heart failure. List only one cause on been line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Due to long a a consequence op:
Ficate be execuphysician and ne prior to burner traumatic	CERTIFICATION	Sequentially list conditions, if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events  OUE TO (OR AS A CONSEQUENCE OF)  OUE TO (OR AS A CONSEQUENCE OF)
atten	CER	resulting in death) LAST
ORC that the	MEDICAL	PART ii. Other algnificant conditions contributing to dasth but not resulting in the underlying cause given in Part i. 24e. WAS AN AUTOPSY FINDINGS ANALIABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
AL REC e law requires has been sign Dept, of Heal		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN
그 두 음음 등	SICIAN:	25. WAS CASE REFERREO TO MEDICAL  EXAMINER?  1  YES 2 NO  26. PLACE OF OEATH (Check only one)  OTHER:  4 Noting Home 5 Residence 6 Other (Specify)
O 등 등 등 등	PHY	27. MANNER OF DEATH  28s. OATE OF INJURY (Month, Dey, Year)  28b. TIME OF INJURY WORK?  M 1 YES 2 NO
TSION TTENDING TOR: After after death 28 is ma	TED BY	Accident   Investigation   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Could not be determined   S   Cou
크 그 그 ㅡ	MPLE	CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated.
TO THE MOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: II	COMP	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piecs, and due to the ceuse(s) and menner se stated.  29b. SIGNATURE AND TIME OF CERTIFIER  29c. LICENSE NUMBER  29d. DATE SIGNED (Mighth, Day, Year)
TO THE TO THE De filed	TO BE	( 1 / 1 ) photein D29 769 > 5/1/98
1+0		Land rele ( los D. A loverne 5/6 ~ Kolling Rd dea Ki
		31. BATE FILED (Month, Day, Your)  32. REGISTRAR'S SIGNATURE  MAY 0 2 1995 Full Dawden Ranfall



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

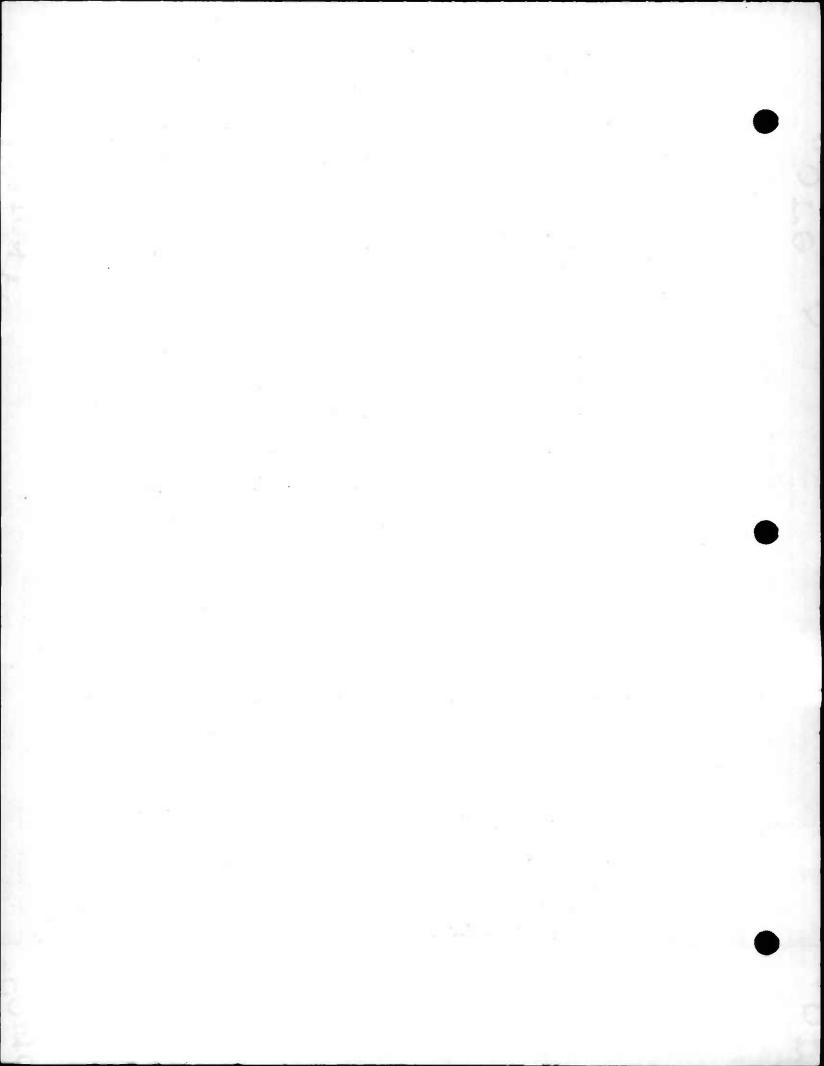
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THE CHANTE HIGHER LOUIS TO THE LA SHOWS SHE HIGHER COMMISSION STORMS COMMISSION THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY O

31. DATE FILED (Month, Day, Year)
MAY 0 2 1995

REGISTRAR SEIGNATURE

						20	1	0100				
	1 - STATE ( REGISTRAR	F MARYLAND / DE	PARTMENT OF H		ENTAL HYGIEN	E						
	1. DECEDENT'S NAME (First, Middle, List)			1	DATE OF DEATH		3.	TIME OF DEATH				
	LYDIA BIS	HOP			April 29	1995	/EAR	3:02PM M				
	4. SOCIAL SECURITY NUMBER 5. SEX	8. AGE (In yrs. last birth	//	IF UNDER 24 HRS. 7	. DATE OF BIRTH	8		ACE (State or Foreign				
- 19	438-02-3740 1 D M 2	XF 76 Y	RS. MONTHS DAYS	HOURS MIN.	Dec. 30, 19	18	Mar	yland				
	9a. FACILITY NAME (If not institution, give street and number	r)	96. CITY, TOWN O	R LOCATION OF DEAT		9c. COUNT						
E	Long View Nursing Home		Manch	astar		Carr	011	County				
5	RESIDENCE OF DECEDENT					Call	OII	oodirty				
DIRECTOR	10a. STATE 10b. COUNTY	100	c. CITY, TOWN OR LOCAT	ION			10	INSIDE CITY				
	Maryland Carroll Co	unty	Manchester				1	YES 2 NO				
¥	10a. STREET AND NUMBER	•	101,	ZIP CODE		10g. CITIZE	N OF WHA	T COUNTRY?				
Ä	3332 Main Street			21102		U.	S.A.					
FUNERAL	11. MARITAL STATUS 12. WAS DEC	EDENT EVER IN U.S. ARMED	13. WAS DECI	ENDENT OF HISPANIC cify Cuban, Maxican, I	ORIGIN? (Specify Yes			American Indian, Vhita, atc.				
ВУ	1 Never Married 2 Married FORCES' 3 Widowed 4 Divorced	1 YES 2 NO		2 NO Specify:	Puarto Mcan, atc.)		Specify:	rima, atc.				
								White				
TED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Give kin	ENT'S USUAL OCCUPATIOn of work done during mos	N et of working	166. KIND OF BUS	SINESS/INDUS	TRY					
۳	Elementary/Secondary (0-12) College (1-4	or 5 +)	VOT use retired.)									
COMPLET	8	U	nknown		U	Inknow	n					
ဗ	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NAME	(First, Middle, Maiden	Sumame)						
BE	Adam Bishop			Unk	nown							
2	19a. INFORMANT'S NAME (Type/Print)		ILING ADDRESS (Street ar									
	Long View Nursing Home		32 Main St									
	20a. METHOD OF DISPOSITION 1 № Burial 2 □ Cremation 3 □ Ramoval from Sta		OATE OF DISPOSITION (Nat			CATION — CH						
	Springfield Cemetery 5/3/95 Sykesville, MD											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  HAIGHT FUNERAL HOME (P.O. Box 195)											
	Druge & Flan	alt		sville. M								
	23. PART I. Enter the diseases, or complication	thet caused the deeth.	Do not enter the mod	da of dyling, such a	as cardiac or respi	ratory arres	195-	Approximata				
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line.											
	IMMEDIATE CAUSE (Finel disease or condition											
	DUE_TO_(OR AS A CONSEQUENCE OF):											
_												
ō	Sequentially list conditions,  OUE TO (OR AS A CONSEDUENCE OF):											
CERTIFICATION	cause. Enter UNDERLYING							İ				
Ĕ	CAUSE (Disease or Injury that initiated events	E TO (OR AS A CONSEQUEN	CE OF):									
E	resulting in deeth) LAST											
5								<u> </u>				
AL	PART II. Other significent conditions contribution	g to death but not result	ting in the underlying	cause given in Pe	ert I. 24a. WAS AN PERFOR			ERE AUTOPSY FINDINGS WILABLE PRIOR TO				
음					_ 1 _ YES 2	-	CC	MPLETION OF CAUSE DEATH?				
M			14.01.00					YES 2 HO				
ż	DID TOBACCO USE CONTRI	BUTE TO CAUSE	OF DEATH '	YES NO								
¥.	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PL	ACE OF DEATH (Check	only one)							
Sic	HOSPITA	L: 2 DER/Outpatient 3 De	OTHER: OA 4 - Mürsing Home	5 🗆 Raaldenca 6 [	Other (Specify)							
PHYSICIAN: MEDICAL		TE OF INJURY 28b	. TIME OF 28c. INJU	JRY AT 2	8d. DESCRIBE HOW IN	NJURY OCCU	RED					
ВУ	1 Hatural 5 Pending	rich, Day, Hear)	M 1 V	ES 2 NO								
	3 Suicide a Could and b 28s. PL	ACE OF INJURY — At home, fo	erm, street, factory, office	2	81. LOCATION (Street a	nd Number or	Rural Rout	e Number,				
回	4 Homicide determined	iding, atc. (Specify)			City or Town, State)							
COMPLET	29a. CERTIFIER Check only CERTIFYING PHYSICIAN: To the b	est of my knowledge death o	coursed at the time date	and place and division	the several and a							
ME	(Check only one) EXAMINER: On the basis							nd manner as stated				
8			,									
띪	29b. SIGNATURE AND THE OF CERTIFIER	,	4	-20C LICENSE NUMBE	ER	29d. OATE S	IGNED (M	ont, Day, Year)				
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED		(Fee Ories)	عا الأكلال	7	- 7	19	(1)				
* 1	THE TOTAL PROPERTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY	WHOSE OF DEATH (HEM 27)	( rype, rmm()									

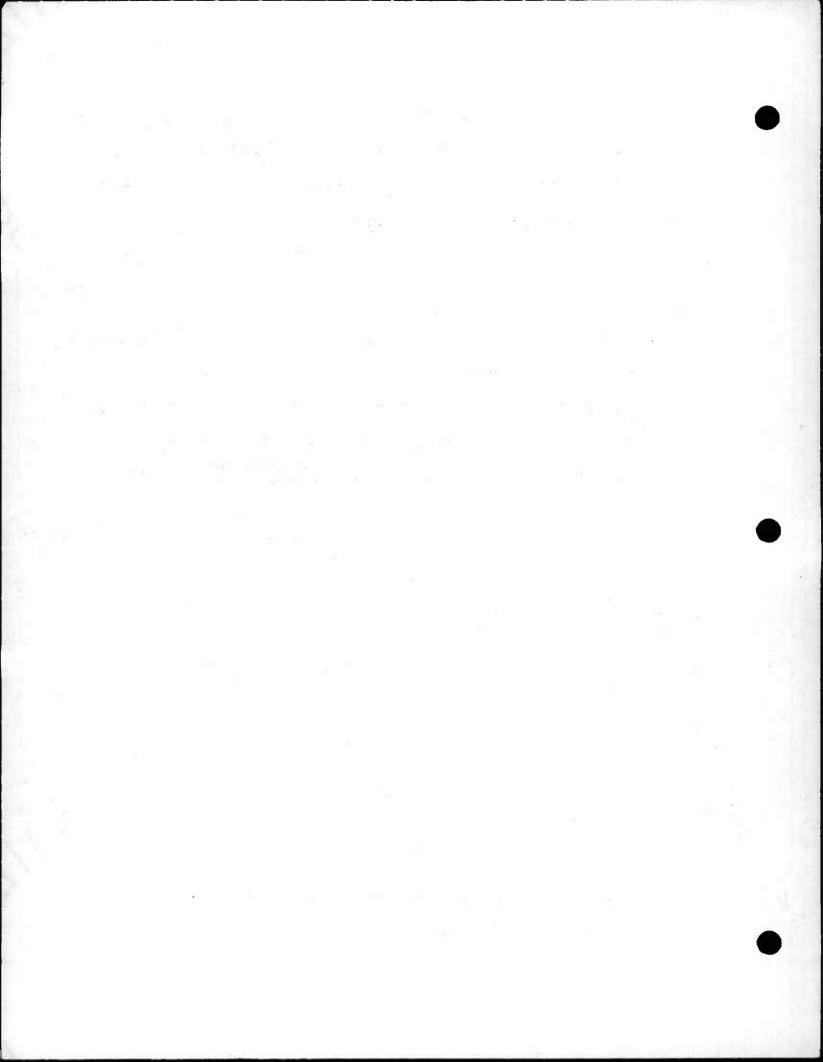
7 67



			FOR STATE REGISTRAR	STATE OF MARY	LAND	/ DEPARTM	ENT OF	HEALTH AND		HYGIENE			
			1. DECEDENT'S NAME (First, Middle, Last)	Barbara T.	Cur	tin			2. DATE OF MONTH	DAY		YEAR	3. TIME OF DEATH  1: 30 A.
Pin			4. SOCIAL SECURITY NUMBER 010-14-4142	1 □ M 2 및 F	76	YRS. MOI	UNDER 1 YEA	B HOURS MIN.	7. DATE OF (Month, Did 11-9)			Countr	PLACE (State or Foreign y) sachusetts
2, 3 should		TOR	98. FACILITY NAME (# not institution, give s  4 Alabama Con RESIDENCE OF DECEDENT			96.		SON	DEATH		Bal-		
permit. Pages 1,		DIRECTOR	100. STATE 106. COUNTY Maryland Balt:			10c. CITY, TO	VSON	CATION					10d. INSIDE CITY LIMITS? 1 YES 2 X NO
. ISI		FUNERAL	100. STREET AND NUMBER 4 Alabama Coun	rt				21204				S.F	WHAT COUNTRY?
215-0020 attending physician. se as the burial-transit		B≼	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 X YES IF YES, GIVE WAR OR	DATES	ARMED NO WW11	If yes,	PECENDENT OF HISP specify Cuban, Maxi (ES 2 XNO Spec	can, Puerto Rica	Specify Yea o	or No-	Black	- American Indian, i, White, etc. ny: White
MARYLAND 21 retained by the hospital or 5 should be detached for u notified at once.		COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		1	DECEDENT'S USU (Give kind of work the. Do NOT use ret Secreta:	done during ired.)	NTION most of working		n Hop			versity
	76	BE CON	17. FATHER'S NAME (First, Middle, Last)  Morris H.	Tuttle				18. MOTHER'S N			umame)		
		0	19a. INFORMANT'S NAME (Type/Print) Cindy C. Baldwin					Court,					204
BALTIMORE, ter death. Page 6 may be the funeral director, page	er must be		20a. METHOD OF DISPOSITION  1 □ Burial 2 ◯ Cremation 3 □ Rem  4 □ Donation 5 □ Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LIC	oval from Stata CE	metery, c	EANDDATE OF DI crematory or other p	rice	Corp. 5-2	2-95		on, N		wn, State Land 21204
BALTIM after death. Page by the funeral direc	wal.		· Wallace	S. Bu	oß	421	Ruc 105	and address of the K Towson  O York Ro	Funera	wson,	Md.	212	204
within 24 hours af	event, the medical		23. PART I. Enter the diseases, prosphore, or heart failure.  IMMEDIATE CAUSE (Finel disease procondition resulting in death)	Example at the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause on the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cau	men III	ne.		Carem		Dr respira	itory arre	nt,	Approximeta interval Betwee Onset and Daar
S, P.O. BOX 6876 death certificate be executed we attending physician and comp	or other traumatic	CERTIFICATION	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated avants resulting in death) LAST	DUE TO (OR AS									
RDS, nat the deat by the atta and Mental y Injury,	y inju	MEDICAL O	PART II. Other algnificant condition							PERFORM	ED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?  1 YES 2 PNO
- R - S	Item 2	SICIAN:	DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 \( \text{YES} \) 2 \( \text{\rightarrow}\) NO	HOSPITAL:  1   Inpetiant 2   ER/Ou	26. PL	ACE OF DEATH (C		()	6 Other (Sp				
ON OF VITA DING PHYSICIAN: The After this certificate h		ВУ РНУ	27. MANNER OF DEATH  1 Netural 5 Pending 2 Accident Investigation	26a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY	28c.	NJURY AT WORK?  YES 2 NO	28d. DESCRI		IURY OCCU	RED	
F SEEDING Affer	2	ETED	3 Suicide 8 Could not be determined	28a. PLACE OF INJUR bullding, etc. (Spe	Y — At I	nome, farm, street	, factory, of	fice	281. LOCATIO City or To	N (Street and own, State)	d Number or	Rural A	oute Number,
D Const		COMPL	one) 2 MEDICAL EXAMINE	CIAN: To the beat of my known on the beats of examination									and manner as stated.
	PORT	O BE	29b. SIGNATURE AND TITLE OF CERTIFIER  30. NAME AND ADDRESS OF PERSON WHO	Hel	EATH (IT	EM 27) (Type, Print	)	DO US		1	≥ 5	SIGNED	(Month, Day, Year)
1	)		Davis M. Hahr					vd. , Bal	timore	, Mar	yland	ł	

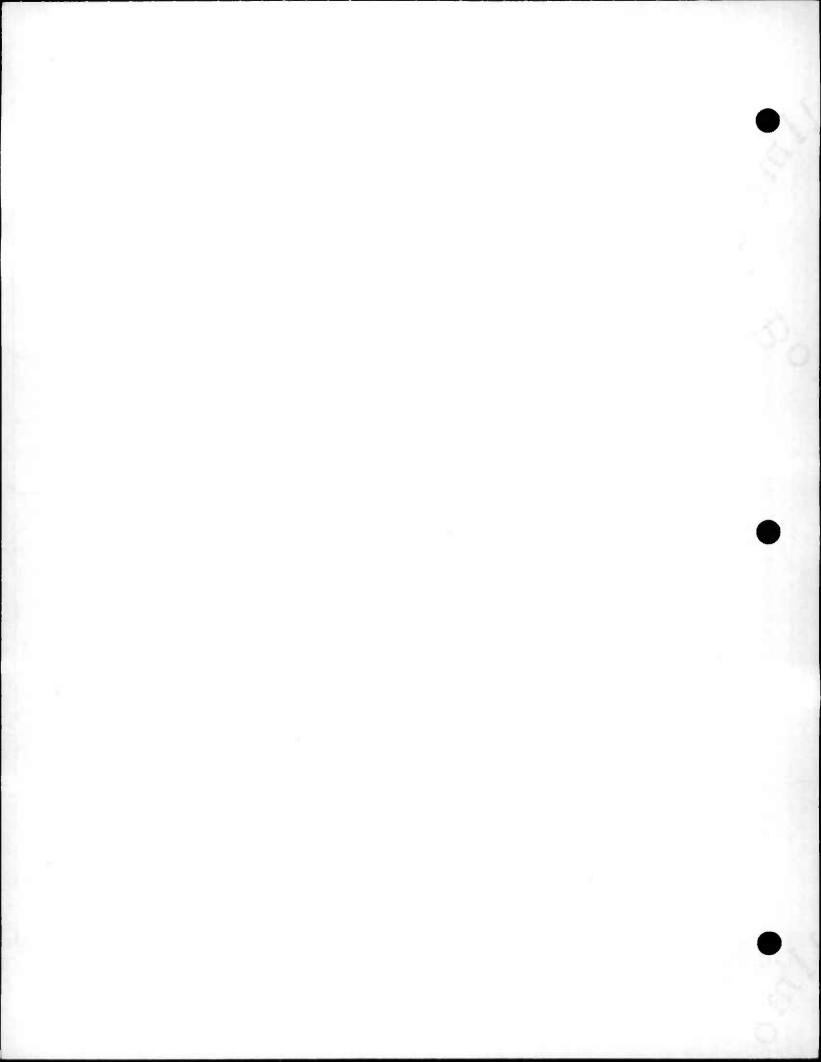
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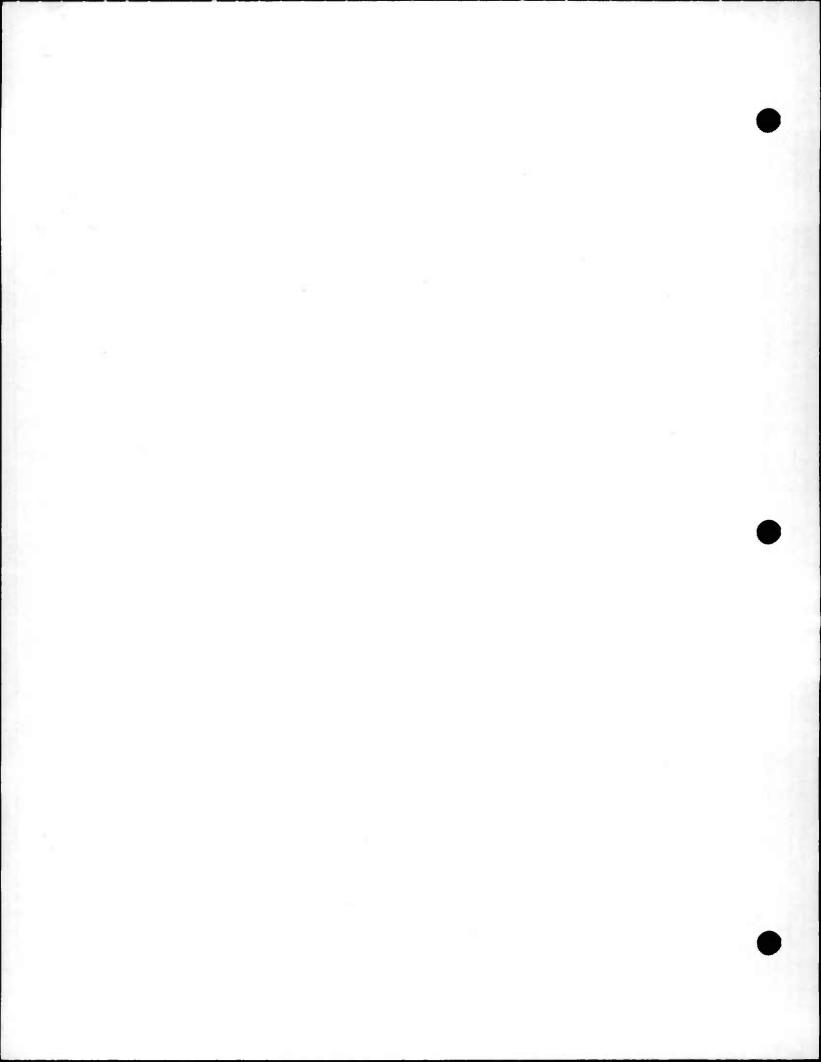
TO BE COMPLETED BY ELINEDAL DIDECTED	O BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
I examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
ine inneres circutos, page o snound de detached not use as the Dutial-Valist permit. Pages 1, 2, 3 should rai.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1.2.3 should	TO THE FUNEAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1.2 should
er death. Page 6 may be retained by the hospital or attending physician.	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.

	1 - FOR STATE OF MA	ARYLAND / DEPA CERTI	ARTMENT OF I	IEALTH AND	MENTAL HYGIEN	E							
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH						
	FRANCES F. CU	MMINGS			May 1	1995	9:10 A W						
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH											
	219-30-1294 1□M2\\F	60 yrs.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) 12-27-1	934 Pe	nnsylvania						
_	Se. FACILITY NAME (If not institution, give street end number)			OR LOCATION OF D		9c. COUNTY OF							
DIRECTOR	1201 S. Marlyn Ave.		Ess	ex		Balt:	imore						
EC	10e. STATE 10b. COUNTY	10c. C	ITY, TOWN OR LOCA	TION			10d. INSIDE CITY						
E	Maryland Baltimore		Esse	Y			LIMITS?						
	10e. STREET AND NUMBER			. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?						
BY FUNERAL	1201 S. Marlyn Ave			21221		USA							
Ę.	11. MARITAL STATUS  1 Never Married 2 Merried FORCES? 1	EVER IN U.S. ARMED	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specify Yee	or No — 14. RA	CE — American Indian,						
34	3 X Widowed 4 Divorced IF YES, GIVE WAI		1 TYES	2 X NO Specif	y:		White						
	15. DECEDENT'S EDUCATION	I ISA DECEDENT	'S USUAL OCCUPATION	DAI	Land warms on our		WILLE						
	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind o	of work done during mo use retired.)	st of working	16b. KIND OF BUS	SINESS/INDUSTRY							
P	12	Homem	naker		N/A								
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NA	ME (First, Middle, Maiden	Surneme)							
BEC	Ralph Farr				E. O'Neal								
5 B	19e. INFORMANT'S NAME (Type/Print)	19b. MAILIN	G ADDRESS (Street	nd Number or Rural	Route Number, Cify or Town	n, State, Zip Code)							
-	Charlene Crouch	8050	Bank S	treet	Baltimor	e, Md	21224						
	20a. METHOD OF DISPOSITION 1 ☐ Buriel 2 🖸 Cremation 3 ☐ Removal from State	20b. PLACE AND DATE cemetery, crematory or	E OF DISPOSITION (No	me of		CATION — City or							
	4 Donation 5 Other (Specify)	Metro C	remator		5-3 Ba	ltimore	e, Md						
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  Connelly Funeral Home of Dundalk											
	Yorthony Colt Cor	inelly	711	0 Sol1e	rs Point	Rd 2:							
	23. PART I. Enter the discusses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory streat, ahock, or head failure. List only one cause on each line.  Approximate interval Retween												
	interval Batwean Onsat and Death												
	disease or condition resulting in death) a. (esperatory Arrest												
	Dy€ TO (O	R AS A CONSEQUENCE	OF):	1									
O	Sequentially list conditions,  Due TO (OR AS A CONSEQUENCE OF):												
¥	csuse. Entar UNDERLYING	THE RESIDENCE	O( ).										
F	CAUSE (Disesse or injury that initiated events DUE TO (0	R AS A CONSEQUENCE	OF):				-						
CERTIFICATION	resulting in death) LAST												
- 11	PART ii. Other algnificant conditions contributing to de	and had not a state		300000000000000000000000000000000000000									
MEDICAL	other agrinically conditions continuing to de	isth but not reaulting	in the underlying	g causa given in	Part I. 24a. WAS AN PERFOR		Ib. WERE AUTOPSY FINDINGS AVAILABLE PRIDE TO						
9					1 [] YES 2	NO	CDMPLETION DF CAUSE DF DEATH?						
Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WINCERTAIN												
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		ATH (Check only one)	UNCERTAI	<u> </u>								
Sic	EXAMINER?  1 YES 2 NO 1 I I Ingellent 2 F	R/Outpatient 3 DOA	OTHER:										
Ŧ	27. MANNER OF DEATH 28e. DATE OF IN	JURY 28b. TI			6 Other (Specify) 28d. DESCRIBE HOW IN	LJURY OCCURED							
ВУР	1 Neturef 5 Pending (Month, Day. 2 Accident Investigation	Year) th	M 1 1	RK? 'ES 2 NO			ĺ						
	3 Suicide 8 Could not be 28e. PLACE OF I	NJURY — At home, farm	, street, factory, offic		281. LOCATION (Street e.	nd Number or Rural	Floute Number,						
IE	4 Homicide determined	( Copounty)			City or Town, State)								
7	29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the beat of my	knowledge, death occur	rred at the time, date	end place, end due	to the cause(s) and men-	ner es stated.							
COMPLETED	one) 2 MEDICAL EXAMINER: On the bag's of exam						(s) end manner es stated.						
шШ	29b. SIGNATURE AND TITLE OF CERTIFIER	0.		29c. LICENSE NUI	IBER	29d. DATE SIGNE	(Moèth, Day, Year)						
œ	Have AVOL	y su	1	1126	835	1 51	1/9-						
임	34. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE	1/				0.							
	Paul A. Valle, Jr., M	.D. 1012	North	Point R	d Baltimo	ore, Mo	21224						
	MAY 0 2 1995												
	MINI O CIOOD OF WHAT	-											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be find within 72 hours after death with the State Date of Health and Merical Horizone proposition or removed.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

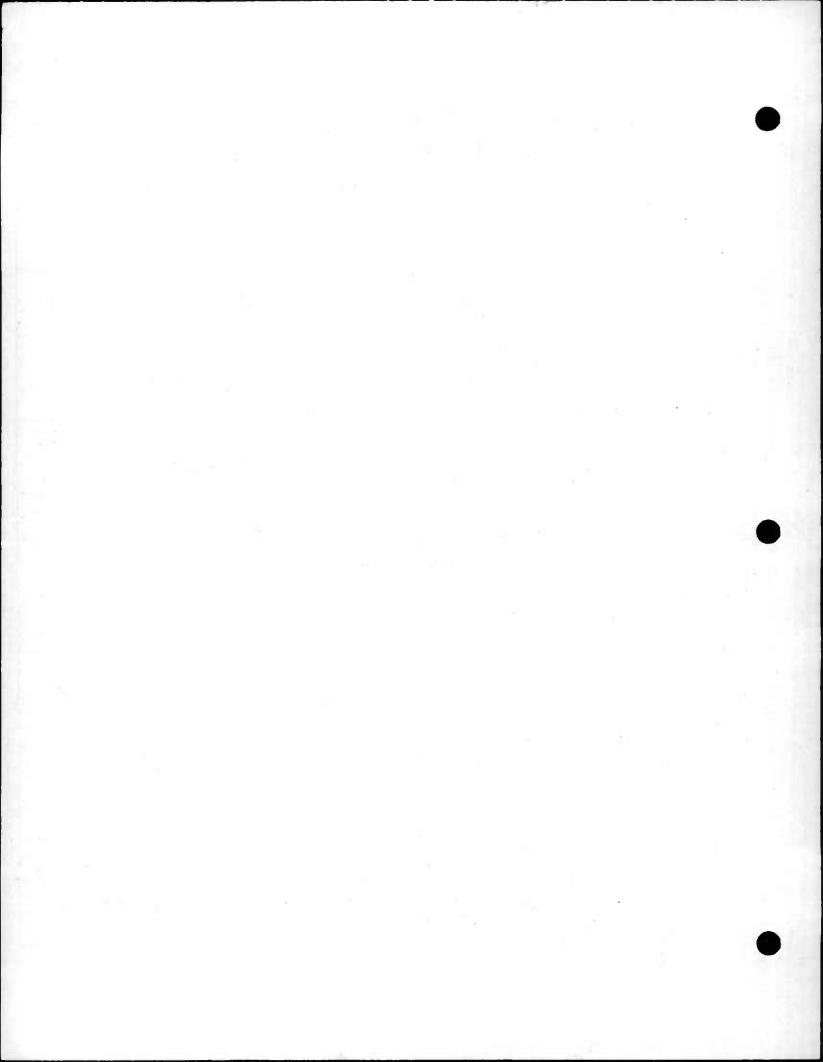
											2	)	0100
	1 - FOR STATE REGISTRAR		STATE OF I	MARYLAND	/ DEPAR	RTMENT	OF H	EALTH AND	MEN	TAL HYGIEN	E		
	1. DECEDENT'S NAME (First,	,								ATE OF DEATH		YEAR	3. TIME OF DEATH
	WINIFRED		LEMSON	LEMSON					4		-199	5	5:05 a M
	4. SOCIAL SECURITY NUMB	599	5. SEX	6. AGE (In yrs. 94	lest birthday) YRS.	IF UNDER 1	DAYS	IF UNDER 24 HRS	(A	ATE OF BIRTH forth, Day, Year) CT. 30	00	Country	PLACE (State or Foreign ) RYLAND
	9a. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CITY,	TOWN C	R LOCATION OF	DEATH		9c. COUN	NTY OF DE	
DIRECTOR	ROLAND PA		LACE			BA	ALT:	IMORE			N/A		
R	10a, STATE	10b. COUNTY			10c. CIT	Y, TOWN OF	R LOCAT	ION					10d. INSIDE CITY LIMITS?
	MARYLAND  100. STREET AND NUMBER	N/A			F	BALTI		RE CODE			40 017		1 YES 2 NO
FUNERAL	830 WEST	40TH	STREET				101.	21211				U.S.	
ا ۾ ا	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER IN U.S.	ARMED	13. W	AS DEC	ENDENT OF HIS	PANIC OR	IGIN? (Specify Yes		14. RACE	- American Indian.
ВУ	1 Never Married 2 3 Widowed 4 Dive		IF YES, OIVE V	PANO.			2 NO Spe		rto Rican, etc.)		Specify	White, atc.	
60											1		WHITE
ETE	(Specify only	EDENT'S EDUC highest grade	completed)	16a.	Give kind of	work done du	CUPATIO	t of working		16b. KIND OF BUS	SINESS/IND	USTRY	
COMPLE	Elamentary/Secondary (0 1 2	-12)	College (1-4 or 5	•)	HOUS	EWIF	Έ			HOM	EMAK	ER	
Ö	17. FATHER'S NAME (First, MI	ddle, Last)						18. MOTHER'S	NAME (FI	sı, Middle, Maiden			
BE (	JOHN F.	KLITO	CH					CORA	LE	WIS			
10	19a. INFORMANT'S NAME (7)	,			19b. MAILING	ADDRESS	(Street a	nd Number or Rur	al Route N	lumber, City or Town	n, State, Zip	Code)	
F	D. BUCKEY	CLE	ISON		P.O.	BOX	45	GIBS	ON	ISLAND	,MD.	210	56.
	20a, METHOD OF DISPOSITI	ON 3 Pame	well from State	20b. PLA	CEANDDATE	OF DISPOSIT	TION /Na	me of		ATE 20c. LO			
	4 ☐ Donation 8 ☐ Other	(Specify)		_ LOR	ŔĂĨŇĔ	PAR	KN	AUS.	4/	95 BA1	LTO.	,MD.	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY												
	William K. Laus III HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212.												
	23. PART I. Enter the di	seases, Dr C	omplications tha	t caused tha	death. Do i	opt antar t	he mod	de of dyling, si	uch as c	srdiac Dr respi	ratory arre	eat,	Approximate
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between Onset and Death												
	disesse or condition resulting in death)	<b>→</b>	Det	und -	atic	2							
			DUE TO	OR AS A CON	SEQUENCE O	F):	•	1 /					
Z	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING  DUE TO (OR AS A CONSEQUENCE OF):  Purposes  Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING												
2	CAUSE (Disease or Injui			•		12	- se	ase					
E	that initiated events resulting in death) LAST		DUE TO	(OR AS A CON	SEOUENCE D	F):							
斯	d.												
	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS												
PHYSICIAN: MEDICA	(musting thousand failure) PERFORMED? MARIABLE PRIOR TO COMPLETION OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE ETVIN OF CAMPLE E												
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2	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										I L YES 2 NO		
A	25. WAS CASE REFERRED TO		MOTE TO CA		LACE OF DEA			ONCERIA	1114				
Sic	EXAMINER?		HOSPITAL:			OTHER:							
Ξ	27. MANNER OF DEATH		28a. DATE OF		28b. TIM		ng Home	5 Residenc	_	ther (Specify) DESCRIBE HOW IN	I II IBY OCC	UDEO	
		Pending	(Month, D	ny, Year)		URY	WOF		200,	DESCRIBE NOW IN	IJUNT OCC	UNED	
ВУ	2 Culaida	nvestigation	26e, PLACE O	F INJURY At	home, farm,	street factor			261 1	OCATION (Street a	and Moundage	o- O( O-	the Marie Co
COMPLETED		Could not be latermined	building,	atc. (Specify)	,				201.6	City or Town, State)	na mamber (	or nurar no	ore rearrable,
Ä	29a. CERTIFIER 1 CERTI	FYINO PHYSIC	CIAN: To the best of	my knowledne	death occurs	ed at the tim	n deta	and place, and d	us to the	omino(s) and ma			
N N													and manner as stated.
	296. SIGNATURE AND TITLE					, -,-	-						The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s
BE	1050						- 1	29c. LICENSE N	713	2	29d. DATE	SIONED	Manth, Day, Year)
2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF DEATH #	TEM 27) /5/0-	Print		03	112	ے			12.
	DONNA DOW						ፓር	WSON.N	۲D -	21204			
1	31. DATE FILED (Month, Day, )			R'S SIGNATURE				511/1		22201	-		
	MAY 0 2 1995	11	Mr. Jan	2.11									



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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH lvin MAXWE April 9:30 1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. a. BIRTHPLACE (State or Foreign DAYS HOURS 1 M 2 - F Maryland anuery Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Harbor Hospital Center Balto.City, Md. none RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland none Balto.City, Md. XXVES 2 NO регтіт. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 1647 S. Hanover St. 21230 United States hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 ∑ YES 2 □ NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or Noit yes, specify Cuban, Mexicen, Puerto Rican, etc.)
 T YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 X Merried BY 3 Widowed 4 Divorced 1961-1964 White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY entary/Secondary (0-12) College (1-4 or 5+) 12th.Grade Auto Machanic none Pep Boys Once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at William Η. Carrol1 BE Irma C. Caha11 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2 Mrs.Marlene S.Carroll 1647 S. Hanover St. Balto. Md. 21230 be 20a. METHOD OF DISPOSITION

1 X Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State Must Md. cometery, crematory or other place)
Md.Vet.cemt.Crownsville 4 Donation 5 Offier (Specify) 4/27/95, Crownsville 22. NAME AND ADDRESS OF FACILITY Balto. Md. 21230 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE McCully Funeral Home, 130 E. Fort Ave the attending physician and completely filled in by the Mental Hydiene prior to burial, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feliure. List only one cause on each line. Interval Batween 50 IMMEDIATE CAUSE (Final **Onset and Death** the cremation, disease Dr condition_ wouldnon resulting in death) mins event. executed within burial, letasta other traumatic CERTIFICATION Dic Sequentially list conditions, prior to OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING death certificate be CAUSE (Disease or injury Hygiene p DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 6 PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS this certificate has been signed by with the State Dept. of Health and AVAILABLE PRIOR TO any COMPLETION OF CAUSE DF DEATH? 1 - YES 2 NO Shows 1 - YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🕱 UNCERTAIN 🗆 PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 TES 2 NO Inpatient 2 - ER/Outpetient 3 - DOA 6 27. MANNER OF DEATH 1 Netural 28e. DATE OF INJURY 26b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, (Month, Day, Year, 5 Pending DIRECTOR: After to hours after death vitem 28 is mark BY 1 YES 2 ND Accident Investigation 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) COMPLETED 6 Could not be 4 Homicide 29a CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(a) and menner as stated. TO THE HOSPITAL OF THE FUNERAL DE BIED WITHIN 72 ho nation and/or investigation, in my opinion, death occured at the time, data and place, and due to the ceuse(a) and menner as stated. 296. SIGNATURE AND TITLE OF CENTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month. Day, Year) BE 5 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print S. Hannus 31. DATE FILED (Month 1995 02



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Fnours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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	FOR 1 - STATE REGISTRAR	STATE OF N	MARYLAND C	DEPAR	TMENT	OF H	EALTH DEAT	AND I		IYGIENI REG. NO.	E		
1	1. DECEDENT'S NAME (First, Middle, Last)					-			2. DATE OF	DEATH	м.	WEAR	3. TIME OF DEATH
1	Marion Fra	nces Car	ney						April	24		995	9:31 Am
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. Is	st birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF I (Month, Da	виятн 1	916	6. BIRTH	PLACE (State or Foreign
	215 10 8022	1 🗌 M 2 🖾 F	7	8 VRS.	MONTHS	DAY8	HOURS	MIN.	Octobe			Count	w. VA.
- 3	Sa. FACILITY NAME (If not institution, give str	set end number)			9b. CITY	TOWN O	R LOCATIO	ON OF DE		-1 12		NTY OF 0	
Œ	6225 York Road #E	416				ltim					JE. 000		- CAIN
DIRECTOR	RESIDENCE OF DECEDENT	110			Ба	TUTH	ЮТЕ						
Ä.	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN C	R LOCAT	ION				-		10d. INSIDE CITY LIMITS?
	MD			E	alti	more							11 YES 2 NO
A	10e. STREET AND NUMBER					101.	ZIP CODE	E			10g. CIT	IZEN OF V	VHAT COUNTRY?
8	6225 York Road						212	12				USA	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN			13.	WAS DEC			IC ORIGIN? (S	pecify Yee	or No-		- American Indian,
	1 Never Married 2 Merried	FORCES? 1	YES 2 X	NO		If yes, spe	2 NO	n, Mexica	n, Puerto Ricar	n, atc.)		Bleci	k, White, etc.
B	②☐ Widowed 4 ☐ Divorced							opeury	,.			Speci	white
	15. DECEDENT'S EDUC. (Specify only highest grade of		16a, O	ECEDENT'S	USUAL O	CCUPATIO	N		16b. KIA	O OF BUS	INESS/INC	USTRY	
ᄪ	Elementary/Secondary (0-12)	College (1-4 or 5	, ,	Give kind of a e. Do NOT us	work done ( se retired.)	during mos	st of workin	g					
릴	12	2		air S	tyli	st							
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				4		18. MOTH	IER'S NA	ME (First, Middl	e, Malden S	Surneme)		
	J.W. Shillinburg							izab			,		
BE	19a. INFORMANT'S NAME (Type/Print)		19	D. MAILING	ADDRESS	(Street a)		_	Poute Number, (	Office of Town	Stein 7in	Code	
2	John J. Carnev								oenix,				
	20s. METHOD OF DISPOSITION		20b. PLACE	_				, FII	DATE		211		
	1 Burlel 2 Cremetion 3 Remo	val from State	cemetery, cr			I I ON I MAI	ne or		DATE	20c. LOC	CATION —	City or 10	wn, State
	21. SIGNATURE OF PUNERAL SERVICE LICE	NSEE RODA	1d Wada	Dáx	22	NAME AN	D ADDRES	S OF FA	CILITY C.	1. A			
	1-101.111	// Kolla	iu waue	, DII		E	ח - מ	7 4 4	CILITY Sta	ite A	nato	my B	oard
	WWW/////	Jule							ore St				D 21201
	23. PART I. Enter the diseases, or co shock, or heert failure. L	emplications the	caused the d	esth. Do r	ot anter	the mod	de of dyl	ng, suci	h sa cerdiec	or reeple	ratory an	reat,	Approximata
Į.	IMMEDIATE CAUSE (Final	ist only one cau	ee on eech iii	♥.									Interval Between Onset end Dasth
1	disease or condition resulting in death)	606	DIDDI	/ MA	1720	111		11	1007				
	rounting in county	DUE TO	OR AS A CONSE	DOENCE D	V/1/C	7	_	TK	Nes-				+
z		8	COP	1					/				
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate	DUE TO	OR AS A CONSE	QUENCE O	Pj	_	1	7			2/	7	h
3	CAUSE (Disease or Injury		and a	1	111	( )	(/	m	6	1	RI	200	/ )
트	that initiated events	OWE TO	OR AS A CONSE	OUENCE OF	7:	~		u.e.d.	- Ch	1	50	200	
E	resulting in death) LAST		mores	si_		An.			ml		Som	. / -	1
2	PART II ON		1		-	<i>/-/u</i>				- 4	700	1	
A	PART II. Other algnificent conditions	contributing to	deeth but not	reaulting i	n the un	derlying	ceuee g	lven in	Part 1. 24s	. WAS AN /		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDICAL									_    10	YES 2	□ NO		COMPLETION OF CAUSE OF DEATH?
W													1 YES 2 NO
	DID TOBACCO USE CONTR	IBUTE TO CA	USE OF DEA	ATH YE	S 🗆 1	10 D	UNC	ERTAIN					
Ĭ Į	25. WAS CASE REFERRED TO MEDICAL			CE OF DEAT									
PHYSICIAN:		HOSPITAL: 1 Inpatient 2	ER/Outpatient	3 NOOA	OTHER	t: Ina Home	s Nad	sidence	6 Other (Sp	ec/fir)			
主	27. MANNER OF DEATH	26e. DATE OF	INJURY	26b. TIM	E OF	26c. INJU	-	I	28d. OESCRIE		LIURY OCC	CURED	
	1 Statural 5 Pending	(Month, D	ly, Year)	160	URY M	1 Y		NO					
à I	2 Accident Investigation 3 Suicide & Could not be	28s. PLACE O	FINJURY — At h	ome, term, a	treet, fecti				281. LOCATID	N (Street er	nd Number	or Bural B	Inute Mumber
- 11		building,	atc. (Specify)		DO SE					wn, State)	J. Tallingon	or restait fi	removi,
- 11	4 Homicide determined												
- 11	an official	IAAI. To at a const			Jeyre I				-				
- 11	29a. CERTIFIER (Check only												
COMPLETED	29a. CERTIFIER (Check only												and manner ee stated.

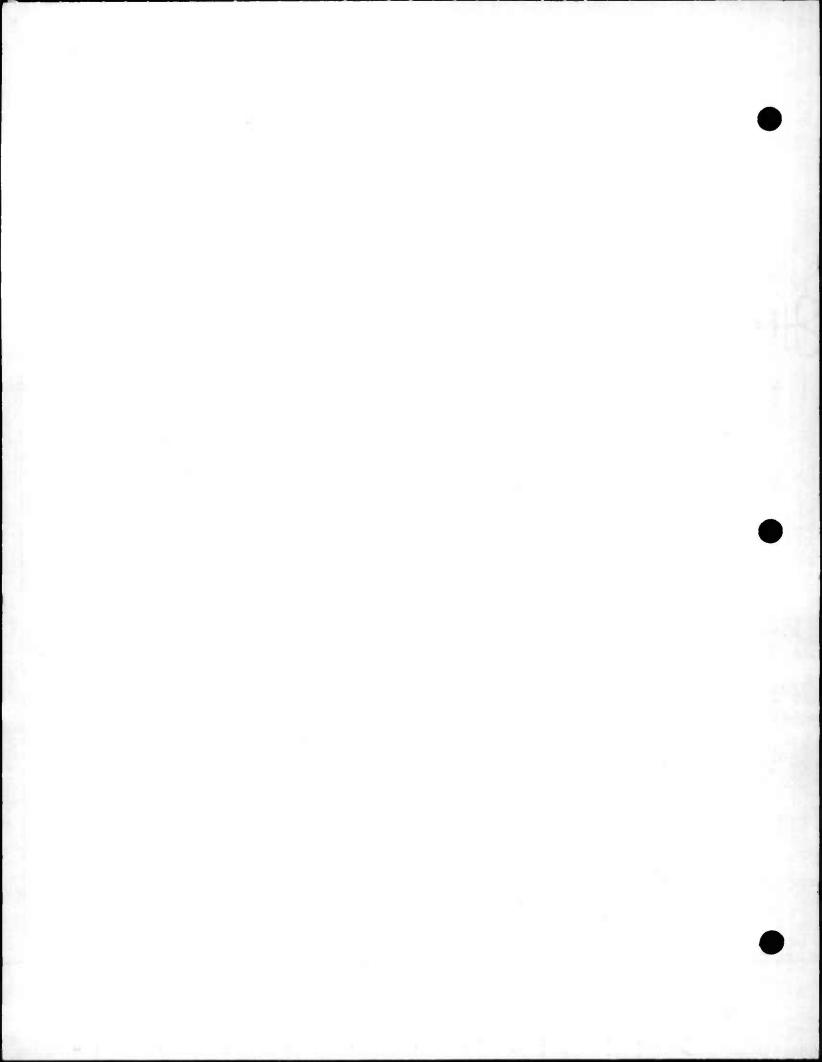
PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

7505 Osler Dr. #312 Richards Dr. Towson MD. 21204

31. DATE FILED (Month, Day, Year)
MAY 0 2 1995

5

32. REGISTRAR'S SIGNATURE Mer Radall



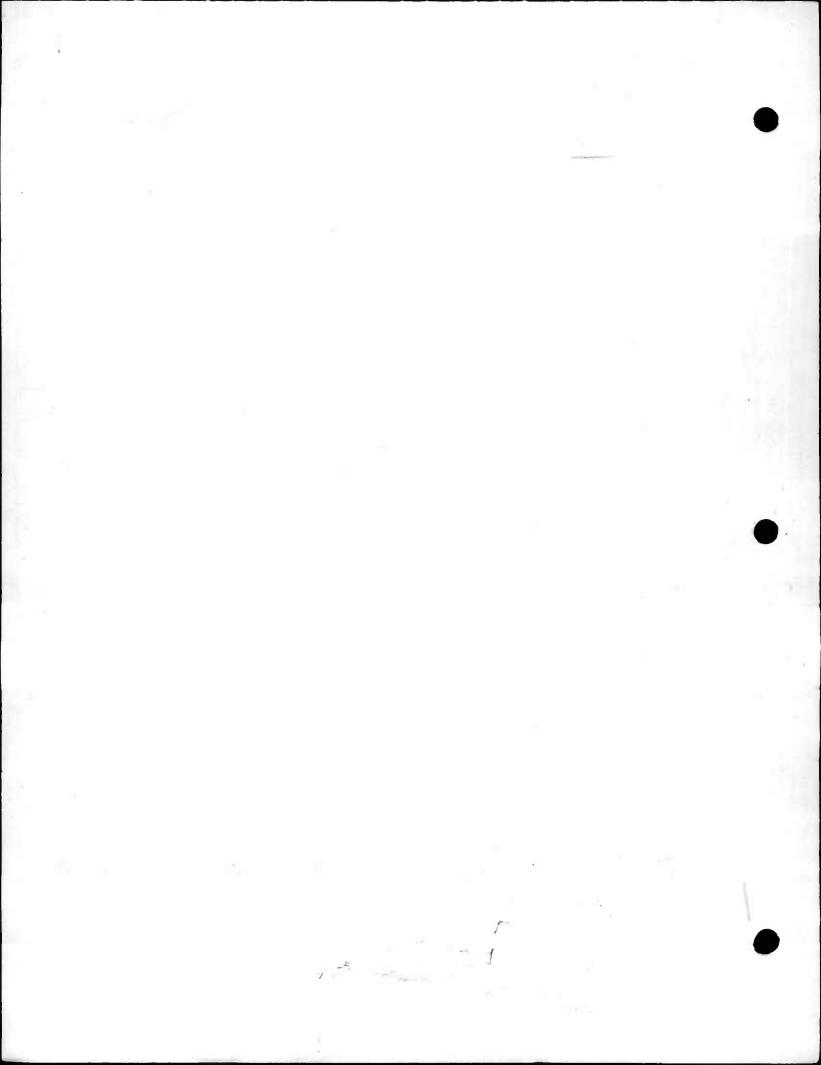
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. — hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit pe		ei ei
may be retained by the	r, page 5 should be del		st be notified at on
urs after death. Page 6	in by the funeral director	r removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
executed with ho	an and completely filled	to burial, cremation, o	umatic event, the m
the death certificate b	y the attending physicia	nd Mental Hygiene phon	injury, or other tra
I. The law requires that	cate has been signed b	State Dept. of Health ar	Item 23 shows any
ATTENDING PHYSICIAN	ECTOR: After this certifi	s after death with the	1 28 is marked, or
TO THE HOSPITAL OR	TO THE FUNERAL DIRI	be filed within 72 hour	IMPORTANT: 11 iten

I	tem4,Film723,5/2/95,lt						95	13191
	1 - STATE REGISTRAR	STATE OF MARYL		RTMENT OF H		MENTAL HYGIEN	_	
	1. DECEDENT'S NAME (First, Middle, Last)	P.				2. DATE OF DEATH		3. TIME OF DEATH
	Vincent Davis	s JR.				Aptil 16	9	
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		IRTHPLACE (State or Foreign
	219-62-7301	1-√2 M 2 □ F	38 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year)		ountry)
	9a. FACILITY NAME (If not institution, give		30	9b. CITY. TOWN	OR LOCATION OF	OCT. 16,	9c. COUNTY O	
Œ	JOHN HOPKINS	HOSPITAL			IMORE C		HETCH STATE	A DEATH
DIRECTOR	RESIDENCE OF DECEDENT	HUSPITAL		DALI	IMORE C	LII	N/A	
Ĕ	10a. STATE 10b. COUNT	Υ	10c. CI	TY, TOWN OR LOCA	TION			10d. INSIDE CITY
ā	MARYLAND	N/A		BALT	IMORE C	ITY		LIMITS?
AL	10e. STREET AND NUMBER			10	. ZIP CODE		10g. CITtZEN	OF WHAT COUNTRY?
E	5302 CHANDLER A	VENUE			21207		US	SA.
FUNERAL	11. MARITAL STATUS SINGLE	12. WAS DECEDENT EVER I FORCES? 1 YES	N U.S. ARMED	13. WAS DEC	ENDENT OF HISPA	ANIC ORIGIN? (Specify Yea		RACE — American Indien, Black, White, atc.
	1 Never Merried 2 Married	FORCES? 1 YES	2 NO		ecify Cuben, Mexic	en, Puarto Rican, atc.)		Black, White, atc.
ВУ	3 Widowed 4 Divorced				74	,		ACK
	15. DECEDENT'S EDI (Specify only highest grad	JCATION e completed)	16a. DECEDENT	S USUAL OCCUPATION Work done during mo	ON set of working	16b. KIND OF BUS	SINESS/INDUSTR	RY .
됴	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT	use retired.)	ot or worning	1		
COMPLETED	11th GRADE		CONS	TRUCTION	WORKER	CONSTRU	CTION C	OMPANY
Ö	17. FATHER'S NAME (First, Middle, Last)				Y	AME (First, Middle, Maiden		
ш	VINCENT M.	DAVIS			GLADYS	5 V.	ВС	WSER
B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILIN	G ADDRESS (Street of	and Number or Rura	I Route Number, City or Tow	n, State, Zip Code	))
2	GLADYS V. JOH	INSON	5302	CHANDLER	AVENUE.	, BALTIMORE	. MARYI	AND 21207
	200. METHOD OF DISPOSITION	201		OF DISPOSITION (N			CATION — City of	
	1 X Buriel 2 Cremetion 3 Ren 4 Donetion 5- Other (Specify)	noval from State cen	netery, crematory or	other place) CEMETERY	,	4-21-95 BAL		
	21. SIGNATURE OF FUNERAL SERVICE L		1. 2100		ND ADDRESS OF F		TIPORE,	MARILAND
	- Oral	2 0.1	m	JOSE 1913	PH H. BE W. BALT	ROWN JR FUN FIMORE ST	ERAL HO	OME, P.A. NORE, MD.2122
	23. PART I. Enter the diseasee, or	complications that cause	d the deeth. Do					Approximata
- 1	immediate cause (Final	List only one ceuse on e	each line.					Onset and Des
	diseese or condition	261		· 1				
1	reaulting in death)	e. M1	A CONSEQUENCE	Tubercu	losis			
7	_	Wa	sting	syndrom	e			j
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	0.	A CONSEQUENCE	*				
AT	ceuse. Enter UNDERLYING	En	d stag	e ATDS				
Ĕ	CAUSE (Disesse or Injury that initiated events		A CONSEQUENCE					
F	resulting in deeth) LAST	a PC	D i o	Pneumo	nia			
8								
AL	PART ii. Other aignificant condition	ns contributing to death t	but not resulting	in the underlyin	g ceuee given is	n Part i. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDING AVAILABLE PRIOR TO
MEDICAL						1   YES 2		COMPLETION OF CAUSE OF DEATH?
Ä								1 YES 2 NO
-								
¥	25. WAS CASE REFERRED TO MEDICAL			26. P	ACE OF DEATH (C	thack only one)		
Sic	EXAMINER?	HOSPITAL:	patient 3 [] DOA	OTHER:		6 K Other (Specify)		
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF INJURY	26b. TI		URY AT	28d. DESCRIBE HOW I	NJURY OCCURE	0
	1 Netural 5 Pending	(Month, Day, Year)	10	IJURY WO	YES 2 NO			
BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY	Y — At home, farm			261. LOCATION (Street a	and Alumbas as Di	ent Bouts Number
입	4 Homicide detarmined	building, atc. (Spe	icity)	, according to the		City or Town, State)	ING NUMBER OF PL	rei noute Number,
Щ	200 CERTIFIED					1	-	
APL		BICIAN: To the best of my know						
COMPL	2 MEDICAL EXAMIN	ER: On the besis of exemination	on and/or investigat	ion, in my opinion, o	leath occured at th	a time, data and place, an	d dua to the cau	rse(a) and manner ea stated.
ш	296. SIGNATURE AND TITLE OF CERTIFIE	R D D	_		29c. LICENSE NO	JMBER	29d. DATE SIG	NED (Month, Day, Year)
00	Z Tewe	lele	M		D 43	501	▶04.	10.95
2	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DE	EATH (ITEM 27) /Tor	e Print)	- 10	201	- / '	177

Zerabruck Tewelde, BCDC

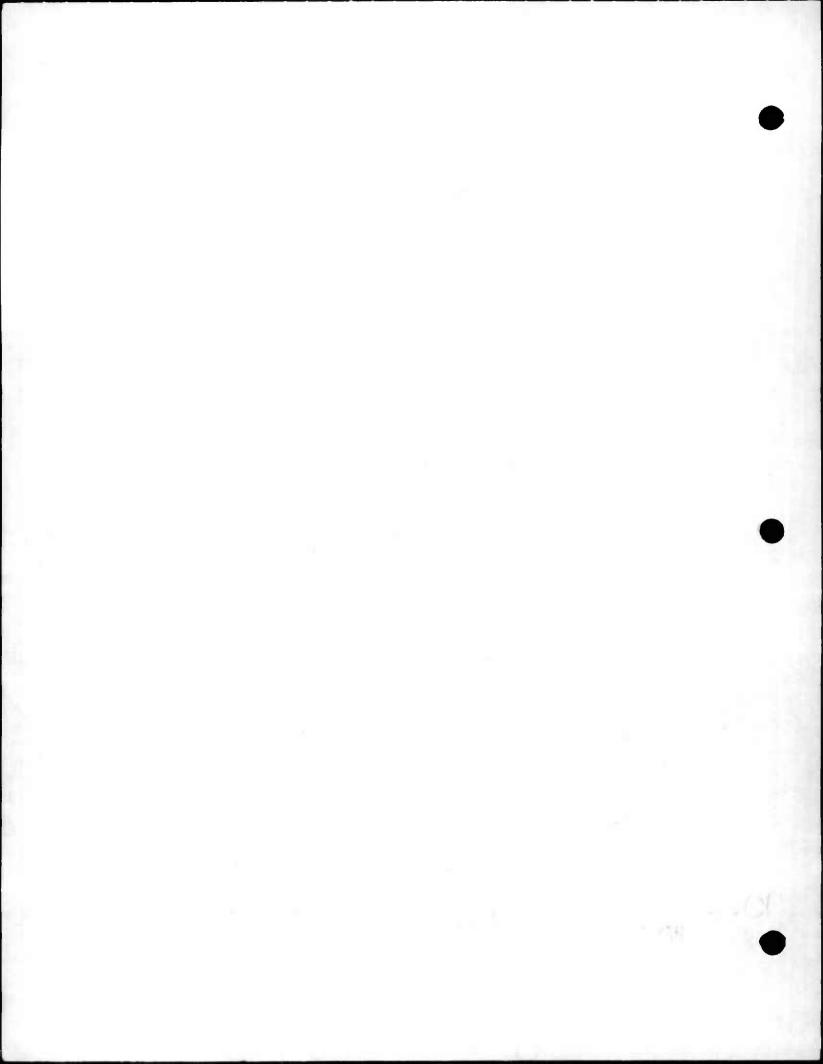
31. DATE FILED (Month, Day, Year)

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		1 - FOR STATE OF MARYLAND / I REGISTRAR	DEPARTMENT OF HEALTH ANI RTIFICATE OF DEATH	D MENTAL HYGIENE REG. NO.	
		1. DECEOENT'S NAME (First, Middle, Last)  Jean Bailey Dille		2. DATE OF DEATH MONTH MAY 01, 199	YEAR 7:45 A M
29		4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last to 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		s. 7. DATE OF BIRTH	8. BIRTHPLACE (State or Foreign Country) Pennsylvania
2, 3 should	ECTOR	9a. FACILITY NAME (If not institution, give street and number)  1046 Old County Road  RESIDENCE OF DECEDENT	96. CITY, TOWN OR LOCATION OF Severna Park	DEATH 9c. CO	ne Arundel
permit. Pages 1,	DIREC	100. STATE 10b. COUNTY Maryland Anne Arundel	10c. CITY, TOWN OR LOCATION Severn	a Park	10d. INSIDE CITY LIMITS? V 1  YES 2 1 NO
tis	FUNERAL	1046 Old County Road	10f. ZIP COOE 2114	10g. CI	TIZEN OF WHAT COUNTRY?
21215-0020 al or attending physician. for use as the burial-transit	ВУ	11. MARITAL STATUS  1 Never Married 2 Married  3 Widowed 4 Divorced  12. WAS DECEDENT EVER IN U.S. ARM FORCES? 1 YES 2 NO. IF YES, GIVE WAR OR DATES	13. WAS DECEMBENT OF HIS If yes, specify Cuben, Max 1 YES 2 NO Spe		14. RACE — American Indian, Black, White, atc.
21 6 c	COMPLETED	(Size Completed) (Give Elementary/Secondary (0-12) College (1-4 or 5+)	EDENT'S USUAL OCCUPATION I kind of work done during most of working to NOT use retired.)  ewife/Mother	Own Home	HOUSTRY
# E E Z	ш	17. FATHER'S NAME (First, Middle, Lest)  Benjamin H. Bailey		NAME (First, Middle, Maiden Surname) Carrie W. Snyd	
	TO B	19a. INFORMANT'S NAME (Type/Print) 19b. Dick S. Diller 10	MAILING ADDRESS (Street and Number or Rul 46 Old County Rd.	ral Route Number, City or Town, State, 2	Cip Code)
6 may stor, pa		4 Donation 5 Other (Specify)	DOATE OF DISPOSITION (Name of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of Concession of	/02/95 Baltimo	re, MD
2 2 2 2		21. SIGNATURE OF FUNERAL SERVICE LICENSEE DAWN F. McDona	299 Frederick	ciety of Marylan k Rd. Baltimore	MD 21228
7 60, ed within 24 hours completely filled in to al, cremation, or re- event, the med	N	552 10 (011 23 2 0013200	(ARL NOW A Y) N(LA ENCE OF):		Onset and Death
th certificate be tending physician all Hygiene prior to or other traus	CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted eventa resulting in death) LAST	ENCE OF):		
L RECORDS, I law requires that the deat as been signed by the atte begt. of Health and Mental 23 shows any injury,	MEDICAL	PART II. Other significant conditions contributing to death but not red		In Part I. 24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
12 6 8 a		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATI 25. WAS CASE REFERRED TO MEDICAL 26. PLACE	TYES NO UNCERTA	AIN 🗆	
SICIAN: The certificate he state I the State I, or Item	PHYSICIAN:	EXAMINER?  1 YES 2 NO HOSPITAL: 1   Inpetient 2   ER/Outpetient 3		ce 8  Other (Specify)	
DING PHYSI After this co death with is marked,	ву Рн	27. MANNER OF DEATH  1 Netural 5 Pending 2 Accident Investigation	28b. TIME OF INJURY AT WORK?  M 1 YES 2 NO	26d. DEŞCRIBE HOW INJURY O	CCURED
ATTEN TOR: after		3 Suicide 8 Could not be 4 Homicide 8 Could not be determined 28e. PLACE OF INJURY — At home building, etc. (Specify)	, 1erm, atreet, 1ectory, offica	281. LOCATION (Street and Number City or Town, State)	er or Rural Route Number,
4 7 5 E	COMPLETE	29s. CERTIFIER (Check only one)  CERTIFYING PHYSICIAN: To the best of my knowledge, destioned one)  EDICAL EXAMINER: On the basic of examination end/or inv			
TO THE HOSPIT TO THE FUNERA De filed within 7	TO BE (	250. SIGNATURE AND BYSE OF CERTIFIER	MD 290 LICENSE N	29d. DA	TE SIGNED Month, Day, Year)
1()		900 Bestgate Rd., Suite 300 Annapo		Peter R. Graze	, M.D.
		MAY 0 2 1995			



permit. Pages 1, 2, 3 should

BALTIMORE, MARYLAND 21

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be featined by the hospital or an THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for up the filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

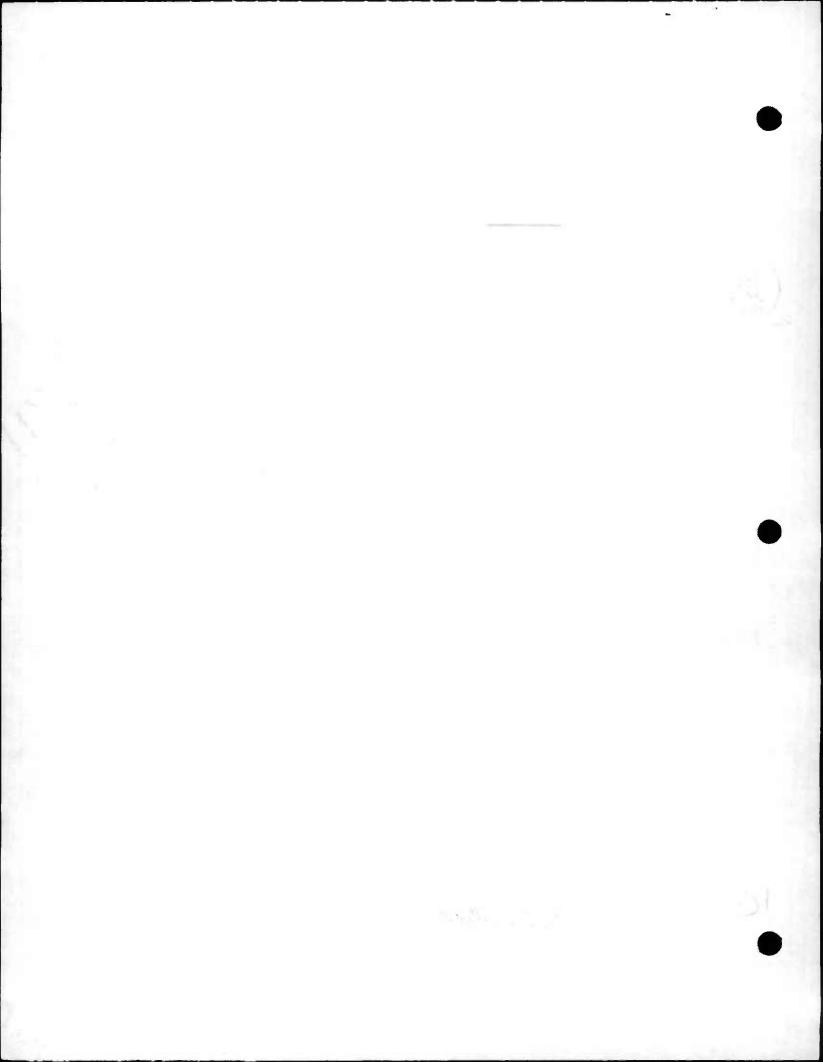
DWG

Item 10b, g-723, 5-3-95, per f.h., dk

FOR STATE						STATE	0F	MA
T C C III	100,	9	1201	~	-	0 - 9	P	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 - STATE REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO		
1. DECEDENT'S NAME (First, Middle, L THOMAS	will			AMOND	2. DATE OF DEATH MONTH D	MY	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER 217-24-4332	5. SEX 6. A	GE (In yrs. last birthday) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	APRIL 2 7. DATE OF BIRTH (Month, Day, Year) Feb. 20, 1		BIRTHPLACE (State or Foreign Country)
90. FACILITY NAME (If not institution, S I - 95 SOUTH O	F RTE 198		96. CITY, TOWN LAURE	OR LOCATION OF D		9c. COUNT	PA Y OF DEATH NCE GEORGES
I-95 SOUTH O RESIDENCE OF DECEDEN 100. STATE 100. CO	UNTY Balti	more 10c. CIT	Y, TOWN OR LOCA				10d. INSIDE CITY LIMITS?
	Harford			adshaw			1 YES 2 NO
10e. STREET AND NUMBER  11203 Pfef:  11. MARITAL STATUS  1 Never Married 2 Merried  3 Wildowed 4 Divorced	ers Road  12. WAS DECEDENT EVE FORCES? 1 図 Y	R IN U.S. ARMED	13. WAS DE	CENDENT OF HISPA	LO21  NIC ORIGIN? (Specify Year), Puerto Rican, etc.)		USA  4. RACE — American Indian, Black, White, etc.
	IF YES, GIVE WAR OF	R DATES	1 🗆 YES	S 2 X NO Specif			Specify: White
15. DECEDENT'S (Specify only highest of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the	College (1-4 or 5+)	(Give kind of life. Do NOT us	WSUAL OCCUPATI work done during manager retired.)	ost of working	16b, KIND OF BU	siness/indu	
12. 17. FATHER'S NAME (First, Middle, Last	)	J Seli-6	employe	T	AME (First, Middle, Maiden		3
Francis V.					va Schaff		
190. INFORMANT'S NAME (Typo/Print) Concetta M. ]		19b. MAILING	ADDRESS (Street	end Number or Rural	Route Number, City or Tow	vn, State, Zip C	ode) Md. 21021
20g. METHOD OF DISPOSITION 1-X Buriel 2 Cremetion 3 4 Donation 5 Other (Specify)	AND THE STREET	20b. PLACE AND DATE of Competery, cromatory or of Belair N	OF OISPOSITION (N	ame of	1 .	CATION — CH	ly or Town, State
21. SIGNATURE OF FUNERAL SERVICE		M-	22. NAME A Mar	NO ADDRESS OF FA	FuneralSe	ervic	
iMMEDIATE CAUSE (Finel disesse or condition resulting in death)  Sequentielly list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury that initiated events resulting in death) LAST	с.	•	F):				Interval Between
PART II. Other aignificant condi	tions contributing to deet	h but not resulting	in the underlyin	g ceuse given in	Part I. 24s. WAS AN PERFOR	RMEO?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
DID TOBACCO USE CO	NTRIBUTE TO CAUSE	OF DEATH YE	S I NO I	LINCEPTAI			OF DEATH?
25. WAS CASE REFERRED TO MEDICA EXAMINER?  YES 2 NO		26. PLACE OF DEAT	TH (Check only one)		ex-kother (Specify)	TCHWI	\V
27. MANNER OF DEATH  1 Netural 5 Pending	28e. DATE OF INJUR (Month, Day, Yea	Y 28b. TIM	E OF 28c. IN.	JURY AT ORK? YES 2 NO	28d. OEŞCRIBE HOW I	NJURY OCCU	
2 Accident Investigati 3 Suicide 8 Could not 4 Homicide datermine	be 26s. PLACE OF INJU-	IRY — At home, farm, a pecify)		•	28f. LOCATION (Street e City or Town, Stete)	end Number or	
	IVSICIAN: To the best of my kn				to the cause(e) end mer	nner ee stated.	
29b. SIGNATURE AND TITLE OF CERT	ne yhell			O.C.M.	MBER	29d. DATE 9	PRIL 26/95
30. NAME AND ADDRESS OF PERSON  ADJUNCTO A  31. DATE FILED (Month, Day, Year)				, BALTI	MORE, MA	RYLAN	ND 21201



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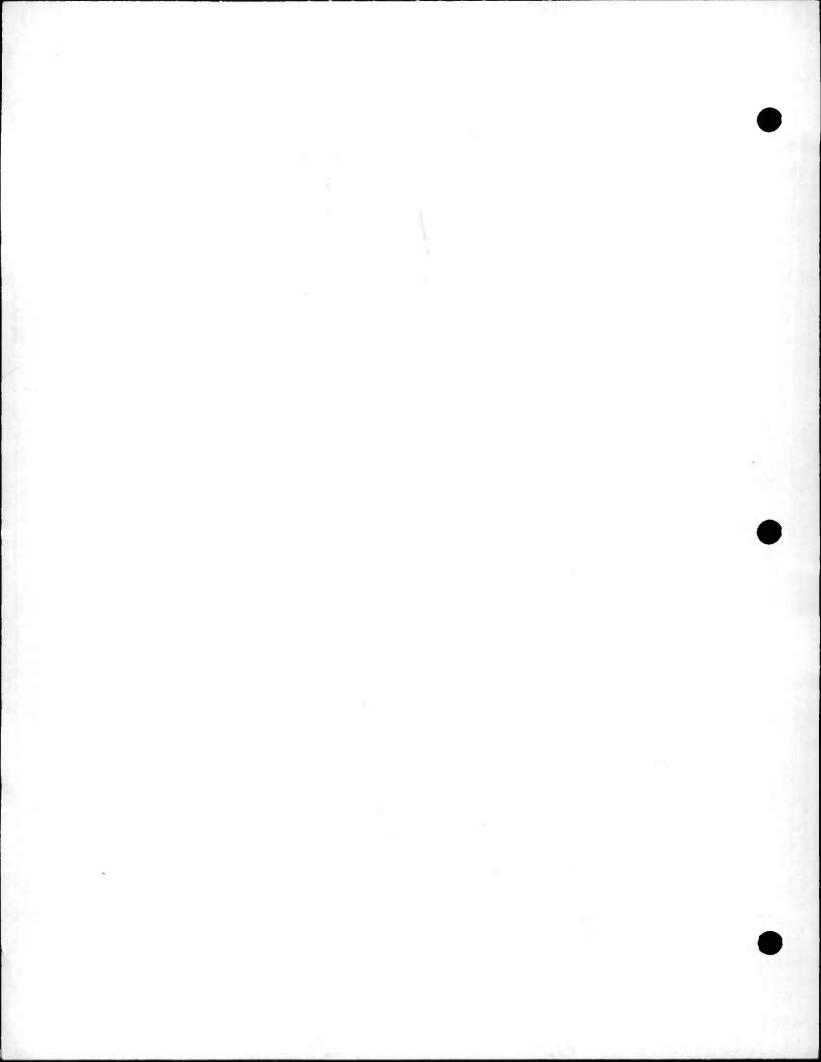
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	IV THE FUNEMAL DIRECTOR: After this certancate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, be filled within 72 hours after death with the State Dept. of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: If them 28 is marked, or them 23 shows any injury, or other traumatic event, the medical examiner must be notified at ence
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR DOROTHY DORAN 5:35 p - 24-95 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 8-26-1921 8. AGE (In vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign DAYS HOURS 1 M 2 F 215-56-5570 73 OKLAHOMA 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 7801 YORK RD. N/A BALTIMORE RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a STATE 10b. COUNTY 10d. INSIDE CITY MARYLAND BALTIMORE N/A 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? 806 WALKER AVEENUE 21212 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuben, Maxican, Puerto Ricen, etc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES ВY 3 Widowed 4 Divorced Specify: WHITE COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KINO OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 6 HOUSEKEEPER HOUSEKEEPER 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) UNKNOWN BE UNKNOWN 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 DEBORAH DeCARLO 7215 YORK RD. BALTO., MD. 21212. 20a. METNOD OF DISPOSITION
1 □ Burlel 2 Cremetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Nama of DATE 20c. LOCATION — City or Town, State GREEN MOUNT CREMATORY 4/95 4 Donation 5 Other (Specify) BALTO., MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HENRY W. JENKINS & SONS CO. ellismk. Kar 4905 YORK RD. BALTO., MD. 23. PART I. Enter the diseases, Dr complications that caused the death. Do not anter the mode of dying, such ee cardiac or respiratory erreet, **Approximate** ahock, or haart failure. List only one cause on each line. intarval Between IMMEDIATE CAUSE (Final **Onaet and Daeth** disease or condition you ardial infaration reaulting in death) DUETO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentielly list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART II. Other aignificant condition MEDICAL atrial fibrill DID TOBACCO USE CON PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL **EXAMINER?** 1 - YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending BY Investigation 2 Accident 3 Suicide 8 Could not be detarmined COMPLETED 4 Homicide

DART II Other circlifficant as all live						
PART II. Other algorificant condition		resulting in the u	indarlying cause given in	PERI	AN AUTOPSY FORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?  1 YES 2 NO
DID TOBACCO USE CONT	RIBUTE TO CAUSE OF DEA	ATH YES 🔯	NO UNCERTAIN	10		
25. WAS CASE REFERRED TO MEDICAL	26. PLA	CE OF DEATH (Check	k only one)			
1 YES 2 NO	HOSPITAL: 1 ☐ Inpatient 2 XER/Outpatient	3 DOA 4 Nu	R: ursing Nome 5 Residence	6 Other (Specify)		
27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28c, INJURY AT WORK? 1 YES 2 NO	28d. DEŞCRIBE HO	28d. DEŞCRIBE HOW INJURY OCCURED		
3 Suicide 8 Could not be determined	28a. PLACE OF INJURY — At h building, atc. (Specify)	ome, farm, street, fac	281. LOCATION (Stree City or Town, St.	CATION (Street and Number or Rural Route Number, ly or Town, State)		
	ICIAN: To the best of my knowledge, d ER: On the basis of examination end/or					
29b. SIGNATURE AND TITLE OF CERTIFIE	Attending		29c. LICENSE NUM 0270	IBER //a	29d. DATE	SIGNED (Month, Dey, Year)
30. NAME AND ADDRESS OF PERSON WA	O COMPLETED CAUSE OF DEATH (ITI	EM 27) (Type, Print)			- 7	
KENNETH GREENE		YORK RD	. BALTO., MI	).		
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						DHMH-16 Rev 1/



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Item

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29b. SIGNATURE AND TITLE OF CERTIFIER

MAY 0 2 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

filled in by the fon, or removal.

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DIRECTOR: After the hours after death v

THE HOSPITAL THE FUNERAL I TO THE HOSPITAL
TO THE FUNERAL I
BE filed within 72 h
IMPORTANT: If II HOSPITAL

cremation, or

BOX 68760 P.O. DIVISION OF VITAL RECORDS, OR ATTENDING PHYSICIAN: The law

ITEM: 3. PER DR. 16b. PER INFORMANT FILM G-728 10/5/95 t.t FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATHOON 12 NOON VEAR Dugger April 1995 24. 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 1 X M 2 F 220-36-1422 Sept.25/ Maryland 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH Sc. COUNTY OF DEATH DIRECTOR Baltimore A.A.Co.Md 217 Werner Rd. 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY A.A.Co. Maryland Baltimore 1 YES 2 NO FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 217 Werner Rd. 21226 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES XXNO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White BY 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic MAREX 12th.Grade Burner Service none Morey Co. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alston Dugger, Sr. BE Opa 1 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Werner Rd. Balto. Mrs. Patricia J. Dugger 21226 A.A.Co.Md. 28a. METHOD OF DISPOSITION 20s. METHOD OF DISPOSITION

12 Burlel 2 Crementon 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Glen Haven Mem.Park,4/29/95 Glen Burnie,Md 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Balto.Md.21230 McCully Funeral Home, 130 E. Fort Ave 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line intervai Batween IMMEDIATE CAUSE (Finei Onset and Death disease or condition resulting in death) Cancer metastate 0/04 DUE TO (OR AS A CONSEQUENCE OF): LIVER 7 month CERTIFICATION 0 Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO WILL UNCERTAIN I PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: 1 Inpetient 2 ER/Outpetient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 26s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident 5 Pending investigation 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, ferm, street, factory, offica building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner ea ateted. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

del

29c. LICENSE NUMBER

P27938

Aguahart Rd. Glea Burnie

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Fhours after death. Page 6 may be retained by the hospital or attending physician.

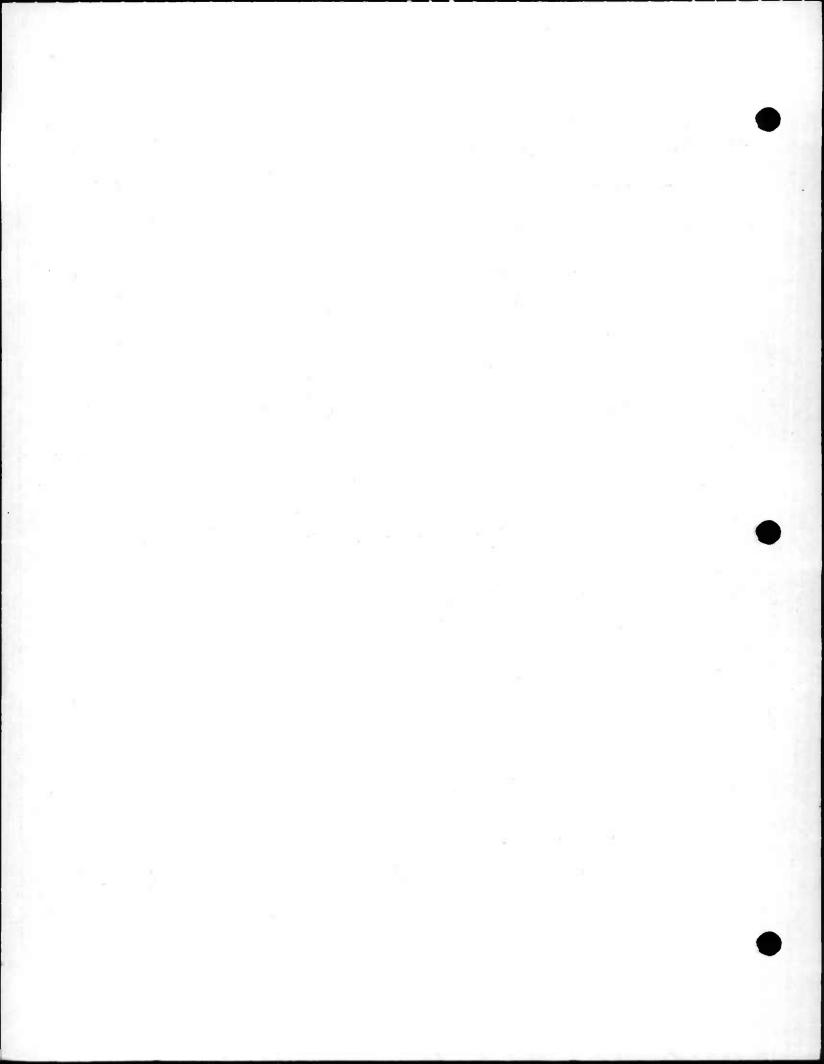
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be find within FO State Dept. of Health and Mental Physien perform to removal.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

BEG NO.

	TIEGIOTTIAN		- Ci	-AIIFI	CAIE	T DEA	IT	RE	G. NO.				
	MONTH DAY VEAR 1									3. TIME OF DEATH 3:00 A. M			
	4. SOCIAL SECURITY NUMBER	A AGE (In um las	6. AGE (In yrs. last birthday) IF UNDER 1			$\overline{}$							
	214-20-1925	5. SEX	83	YRS.	MONTHS DAY		noter 24 Hrs. IRS MIN.  7. DATE OF BIRTH (Month, Day, Year)  June 21,			911 Maryland			
-	9a. FACILITY NAME (If not institution, give				9b. CITY, TOV		ION OF DE	ATH		COUNTY			
DIRECTOR	8 Beech Leaf Co	urt			Towson					Baltimore County			
l ñ	10a. STATE 10b. COUN	ry		10c. CITY	TOWN OR LO	CATION					10d. INSIDE CITY		
		4								LIMITS? 1 ☐ YES XX NO			
FUNERAL	8 Beech Leaf Cou		21286					U.S.A	OF WHAT COUNTRY?				
S	11. MARITAL STATUS	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED						13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-					
	1 Never Married 2 Married	Ю	If yes, specify Cuban, Mexican, Puerto Rican, atc						RACE — American Indien, Black, Whita, alc.				
BY	3 XWIdowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES ZXX NO Specify: Specify: White										White		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT user retired.)  18b. KIND OF BUSINESS/INDUSTRY												
Ë	Elementary/Secondary (0-12)	College (1-4 or 5	+)		retired.)			D-					
g \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	12th Grade		Sal	les					_	it Sto	re		
5 8		17. FATHER'S NAME (First, Middle, Last)						16. MOTHER'S NAME (First, Middle, Melden Surname) Elsie Wesley Smoot					
B B	William Ellwoo	d Burkin						Wesley					
2	19a. INFORMANT'S NAME (Type/Print)  William Roger Day  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  3409 Woodring Avenue, Baltimore, Maryland-21234										o) id-21234		
U Sala	20a. METHOD OF DISPOSITION  1 33 Burlel 2 Cremation 3 Rer  4 Donation 5 Other (Specify)	matory or oth	opposition(Name of the place) Cemetery 5/3					Oc. LOCATION — City or Town, State Baltimore, Maryland					
흔	21. SIGNATURE OF FUNERAL SERVICE L	CENSEE	awii c										
Kathlun M. Murraled John C. Miller,								6415 Belair Road ,Inc. Baltimore,Maryland21206					
CERTIFICATION	23. PART1. Enter the diseases, or compilications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, allowed the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, allowed the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, allowed the interval Batween Onset and Dasth of the death.  Approximate Interval Batween Onset and Dasth of the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory arrest, allowed as a cardisc or respiratory a												
RTIF	CAUSE (Disease or injury that initiated events resulting in desth) LAST												
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY FINDINGS												
MEDICAL CI	PART II. Other significant conditio	death but not n	ut not resulting in the underlying cause given in i				Part I. 24a. WAS AN AUTOPSY PERFORMED?			24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
								_ 10	YES 2	NO	COMPLETION DF CAUSE OF DEATH?		
= =						-/					1 TES 2 NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN													
PHYSICIAN	EXAMINER?												
S X	1 TYES 2 NO		ER/Outpatient 3			iome 5 🗆 R	asidenca 6	Other (Speci	fy)				
BY PH	27. MANNER OF DEATH  28a. DATE OF INJURY  1 Netural 5 Pending 2 Accident Investigation  28b. TIME OF INJURY AT WORK?  1 YES 2 NO  28d. DESCRIBE HOW INJURY OCCURED									D			
	3 Suicida 6 Could not be determined 28s. PLACE OF INJURY — At home, farm, s building, atc. (Specify)					treet, factory, office 281. LOCATION (Street City or Town, Start				t and Number or Rural Route Number, a)			
	29a. CERTIFIER (Check only one)  CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and menner ea stated.  CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and menner ea stated.												
MPLE	(Check only CERTIFYING PHYS	ICIAN: To the best of	my knowledge, dec	oth occurred	I at the time, d	lets and place	, end due to	o the cause(e) e	nd menner	e stated.			
COME	(Check only one) 2 MEDICAL EXAMIN	ER: On the besis of e	my knowledge, dec examination and/or is	nth occurred	I at the time, d	n, death occu	red at the ti	ime, data and pla	aca, and di	ua lo lha cau			
H	(Check only one) 2 MEDICAL EXAMIN 29b. SIGNATURE AND TITLE OF GATTIE	ER: On the bests of e	xemination and/or is	nvestigation	, In my opinion	n, death occu	end due to	ime, data and pla	aca, and di	ua lo lha cau	NED (Month, Day, Year)		
	(Check only one) 2 MEDICAL EXAMIN	ER: On the bests of e	xemination and/or is	nvestigation	, In my opinion	n, death occu	red at the ti	ime, data and pla	aca, and di	ua lo lha cau			
H	(Check only one) 2 MEDICAL EXAMIN 29b. SIGNATURE AND TITLE OF GATTIE	O DOMPLE ED DAN	SE OF DEATH INTEN	nvestigation	, In my opinion	n, death occu	red at the ti	ime, data and pla	aca, and di	ua lo lha cau			

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	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit p	ith the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.	

95 13197 FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle | ast) 2. DATE OF DEATH 3. TIME OF DEATH YEAR WILLIAM **EDWARD** 6.15 P M APR 1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year B. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 213-09-7216 DAYS HOURS 1 M 2 F 88 June 22, 1906 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Bon Secour Hospital Baltimore Balto. City RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Balto, City TES 2 NO Raltimore 101. ZIP CODE FUNERAL 10s. STREET AND NUMBER 10g, CITIZEN OF WHAT COUNTRY? 2747 Raynor Ave. 21216 U. S. A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced Specify: Black BY COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 Unkown Unknown 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) William Williams May Williams BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Glendola Williams 2747 Raynor Ave. Balto. MD 21216 pe 20s. METHOD OF DISPOSITION 20h. PLACE AND DATE OF DISPOSITION /Warre of DATE 20c. LOCATION - City or Town, State 1 Surial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify) must 4-25-95 Balto. MD COTT. oudon Park 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner Estep Bros. Funeral Home. P.A. 23. PART I. Enter the diseases, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

IMMEDIATE CAUSE (First) medical Approximate Interval Betw IMMEDIATE CAUSE (Final Onset and Death the disease or condition ACUTE MYOCARDIAL INFARCTION resulting in death) 4/20/95 event, DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditiona, OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediata cause. Enter UNDERLYING **CAUSE** (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF). that initiated events reaulting in death) LAST 0 PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY any 1 YES 2 NO OF DEATH? shows 1 YES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL:
1 Inpetient 2 ER/Outpetient 3 DOA 1 YES 2 NO OTHER: 4 - Nursing Home 5 - Residence 8 - Other (Specify) 6 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT WORK? Is marked, 28d. DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident 5 Pending Investigation M 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 28 4 Homicide Hem 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(a) and manner as ateted.
2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. Ξ TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: IS 286. SIGNATURE AND TITLE OF CENTURES

SUNTHORN MALAISRIE

NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print,

Payston Street - Baltimore

Jalin Standam Kan

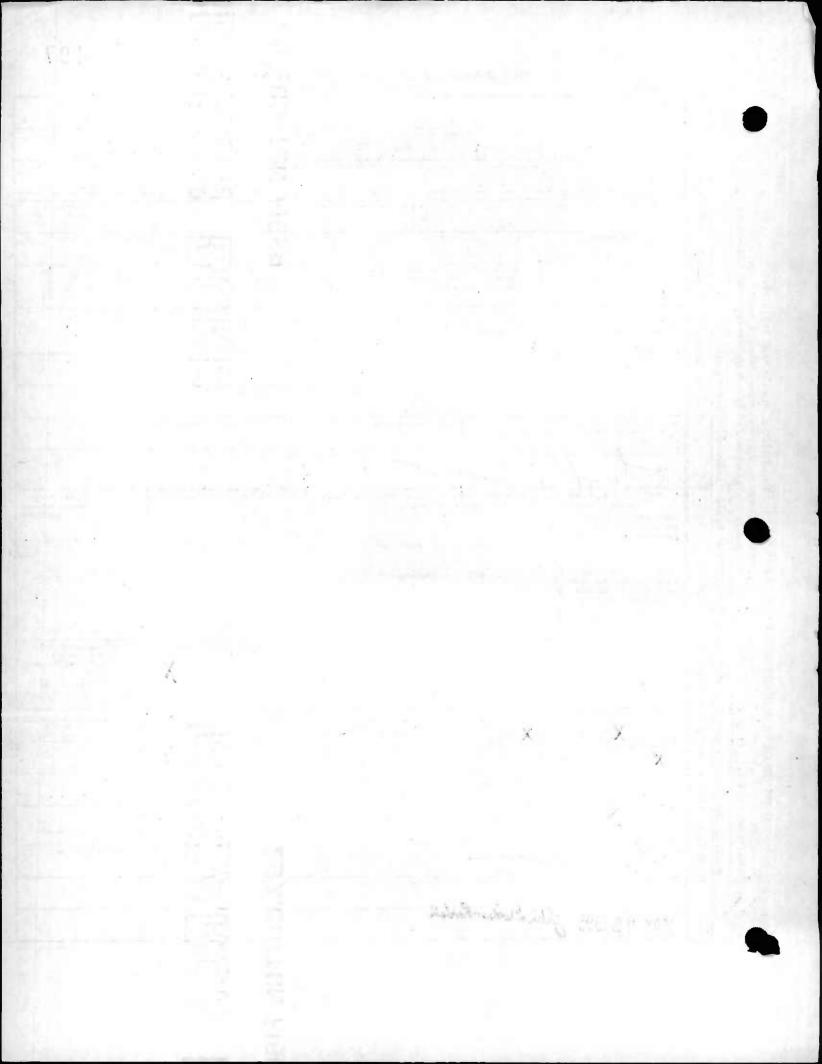
29c LICENSE NUMBER

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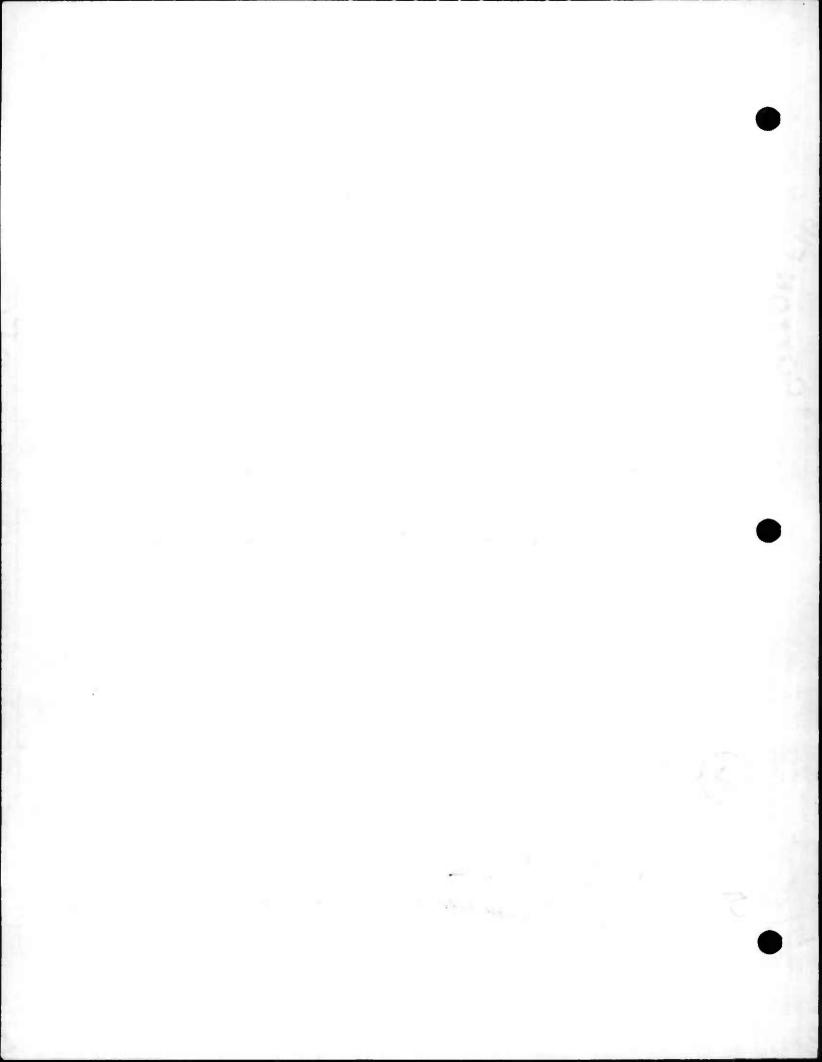
29d. DATE SIGNED (Month, Day, Year)

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		1. DECEDENT'S NAME (First, Middle, Last)						OF DEATH		3. TIME OF	DEATH
			nry	Ellin	ason S	Sr.	Apr		199	5 140	7 M
9		4. SOCIAL SECURITY NUMBER 215 40 3455	5. SEX 1 1 M 2 F 5.	(In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE	OF BIRTH 13 42	6. (	Sountry)  ryland	
3 should	_	Sa. FACILITY NAME (If not institution, give s	treet and number)		9b. CITY, TOWN	OR LOCATION OF D	EATH		9c. COUNTY	OF DEATH	
, 2,	CTO	Honkins at Ray			Balt	imore			N/A		
iit. Pages	DIRECTOR	Md. 10b. COUNTY	?a		y, town on Local altimore					10d. INSIDE LIMITS? LV YES 2	
n. Insit permit,	FUNERAL	100. STREET AND NUMBER 114 South Bould	in Street		10	21224			10g. CITIZEN USA	OF WHAT COUNTE	147
215-0020 attending physician. ise as the burial-transit	B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 TYES IF YES, GIVE WAR OR DO	U.S. ARMED	If yes, s	CENDENT OF HISPA pecify Cuben, Mexic S 2 NO Speci	an, Puarto F	? (Specify Yea o		RACE — American Black, Whita, etc. Specify:	Indian,
S # N	E	15. DECEDENT'S EDU (Specify only highest grade	CATION COMPRISED	16a. DECEOENT'S	USUAL OCCUPAT	ION	16b.	KIND OF BUSIN			
21 for u	APLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Instal		lost or working		Carpet			
YLAN by the hor be detact	E COMPL	17. FATHER'S NAME (First, Middle, Last) Herbert Olaf El		18. MOTHER'S NAME (First, Middle, Malden Sumame)  Cornelia Beatrice Frank							
MAR retained 5 should notitied	TO B	19a. INFORMANT'S NAME (Type/Print) Gloria J.White-H	Ellingson	19b. MAILING	AOORESS (Street	and Number or Rural n St. Ba	Route Numb	er, City or Town,	State, Zip Coo		-
		20a, METHOD OF DISPOSITION	20b	PLACE AND DATE			OATI			or Town, Stata	
BALTIMORE, after death. Page 6 may be by the funeral director, page moval. Ical examiner must be		1 Surial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	Sa	etery, cremetory or o	art of J	Tesus Cem	5-2				
ALTIN death, Pag tuneral dia full examiner		21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE		22. NAME A	IND ADDRESS OF FA	ACILITY				
BALT ter death. the funers wal. si exami	- 5	Charles S. Zeiler & Son Inc. 901 S. Conkling St. Balto., Md.									
within 24 hours pletely filled in t cremation, or re-		23. PART I. Enter the diseases, prospective.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Elist only one cause on e	ech line.		ode of dying, suc					dimate il Between and Daath
OX 6876  e be executed sician and com rior to burial, traumatic ev	CATION	Sequentially list conditions, if any, leading to immediate	D. OUE TO (OR AS A	CONSEQUENCE OF	F):						
E 5 5 0	FICA	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):									
O = 5 = 5	CERTIFI	resulting in desth) LAST									
RD at the by the and M inju	MEDICAL	PART II. Other eignificant condition	s contributing to deeth b	ut not resulting	in the underlyin	ng cause given in	Part I.	24a. WAS AN AL PERFORM 1 YES 2	ED?	24b. WERE AUTOPS AVAILABLE PR COMPLETION OF DEATH?	OT RO
L RECO law requires that as been signed bept, of Health a							[			1 XYES 2	□ NO
	N.	DID TOBACCO USE CONTI		F DEATH YE			N 🔀				
	SICHAN:	EXAMINER?	HOSPITAL:		OTHER:	ne 5 🗆 Rasidence	6 C Other	(Specific)			
	НУ	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. IN	JURY AT		CRIBE HOW INJ	URY OCCURE	D	
	à	Natural 5 Pending Accident Investigation			M 1 🗆	YES 2 NO					
DIVISION OF TO THE HOSPITAL OR ATTENDING PHYSIS TO THE FUNERAL DIRECTOR. After the Se filed within 72 hours the Certifi with IMPORTANT: It from 28 1	E L	3 Suicide 8 Could not be determined	streat, factory, offic	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
TAL OR A		29a. CERTIFIER (Check only one) 2 X MEGICAL EXAMINED. On the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner se stated.									
HOSP FUNE within	ပ္ပ	2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner as stated.									
TO THE HOSPITAL TO THE FUNERAL ( be filed within 72 h IMPORTANT: It i	BE	M	X~ ~			29c. LICENSE NUMBER  O.C.M.E.  29d. DATE SIGNED (Month).  April 2					1995
F F 5 =	2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	. , , , , ,	,						
$\supset$		31. DATE FILEO (Month, Dev (Nett)	A SX. HEGISTRAR'S SIGN	X111 P	enn St	reet, B	alti	more,	Mary	land 2	L201
		MAY U 2 1995									

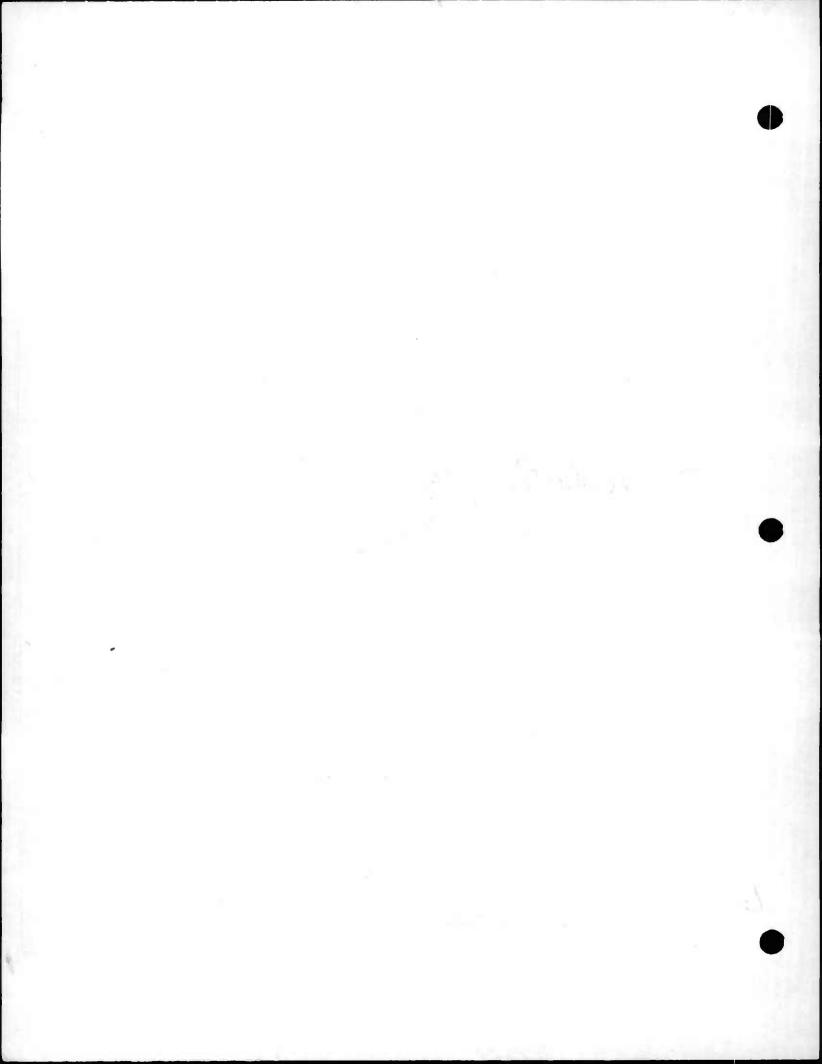


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
OECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH

		1 - STATE REGISTRAR		STATE OF I	MARYLAN	ND / DEPAF CERTIF	RTMEN	OF H	DEAT	AND M	IENTAL	HYGIEN REG. NO.				
		1. OECEDENT'S NAME (First,	ce	P	EI	der					2. DATE (	OF DEATH	NY	YEAR	3. TIME OF OEATH	м
		4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In y	yrs. lest birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE (				PLACE (State or Formign	
pjnc		231-58-9309 9e. FACILITY NAME (If not inst		1 M 2 K F		80 YRS.					07/26	/1914		West	Virginia	
, 2, 3 should	ECTOR	Montgomery Gene	eral Hosp				9b. CIT1		Iney	ON OF OEA	ATH		9c. COUNT Mont	gomer		
iges 1	REC		10b. COUNTY			10c, CIT	Y, TOWN	OR LOCAT	ION						10d. INSIDE CITY	-
.≓. S2	DIR	Maryland	Howa	ard				H	ighlar	nd					LIMITS? 1 YES 2XX NO	
physician. bunal-transit permit. Pages 1,	FUNERAL	100. STREET AND NUMBER 12768 Rt. 216						101	207	€ 777			10g. CITIZE		HAT COUNTRY?	
the fig.	В	11. MARITAL STATUS 1 Never Married 2 N 3 Widowed 4 Divorce	Merried	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	1 YES	2 V NO		If yes, spe	ecify Cuba	OF HISPANIC in, Mexicen, Specify:	, Puerto R	? (Specify Yes licen, etc.)	or No- 1	I4. RACE Black, Specify	- American Indian, White, etc.	
al or	PLETED		DENT'S EDUCA highest grade co			6a. DECEDENT'S (Give kind of life. Do NOT us Homema	work done se retired.)	CCUPATIO during mo	N st of workin	יפי		KINO OF BUS	Home	STRY		
be det	E COMPI	17. FATHER'S NAME (First, Middle, Lest)  Gordon L. Richmond  18. MOTHER'S NAME (First, Middle, Meiden Surneme)  Grace Ames														
be retained to ge 5 should e notified	TO B	190. INFORMANT'S NAME (Type Carole Helmick	pe/Print)			1						er, City or Yowi		2176	69	_
may be		20s. METHOD OF DISPOSITIO		rai from State	20b. PL	LACE AND DATE	OF DISPOS	ITION (Na	me of		DATE	20c. LO	CATION - CI	ty or Tow	rn, State	_
Page 6 ma al director, p ner must		4 Donation 5 Other (S	Specify)		Hol	Ty Memor	_				05/0				le, Virginia	_
death. e funeral. exami	-	21. SIGNATURE OF PUNERAL	Pal	Tall	cad	a	22.			ss of faci Sandy		Fleck Fung Road,			, Inc. aryland 2070	7
within 24 hours at applicably filled in by cremation, or reminent, the medic		23. PART L Pinter the dis- shock, or her IMMEDIATE CAUSE (Fins disease or condition resulting in death)	art isnure. La	wide	(A)	he death. Do r	the	the mo				lac or respi			Approximate Interval Betwee Onset and Dea	
be execucian and for to bur	RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING														
th certifical ending phy il Hygiene is or other	CERTIFIC	CAUSE (Disease or injury that initiated eventa resulting in death) LAST	ONSEQUENCE O	NSEQUENCE OF):								_				
that the ded by the th and Me any injur	MEDICAL	PART II. Other algorifican	t conditions	contributing to	death but	not resulting	in the un	deriying	cause g	iven in P		1. 24a. WAS AN AUTOPSY PERFORMED?		1	WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH?	S
w requires been sign tt. of Heal	Σ.	DID TOBACCO US	E CONTRI	RUTE TO CA	USE OF	DEATH Y	S 🗆 I	NO 🗆	LINC	ERTAIN					1 YES 2 NO	
N: The law icate has be State Dept.	SIAP	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL			PLACE OF DEA	TH (Check	only one)	0110	LIVI7-WI V						_
SICIAN: The lay certificate has the State Dep 1, or item 23	PHYSICIAN:	1 TES 2 HO		HOSPITAL:	☐ ER/Outpatic	ent 3 🗆 DOA	OTHER 4 Num		e 5 🗆 Re	sidence 8	□ Other	(Specify)				
PHY this with	ву рн	27. MANNER OF DEATH  1 Naturel 5 Pr 2 Accident In	ending ivestigation	28e. DATE OF (Month, D		28b. TIM INJ	IE OF JURY M		URY AT RK? YES 2		28d. DE\$0	CRIBE NOW IN	JURY OCCU	RED		
OR ATTENDING DIRECTOR: After hours after death		4  Homicide de	could not be etermined	28e. PLACE C building,	of INJURY — , etc. (Specify)	At home, farm,	street, fact	ory, office	•	2		TION (Street e r Town, State)	nd Number or	Rural Ro	ute Number,	
7 72 =	COMPLETED			AN: To the best of											end menner as stated.	
TO THE HOSPITA TO THE FUNERA De filed within 7 IMPORTANT: I	BE	296. SIGNATURE AND TITLE O	7. U	20 /	1.1	Q , ,	40		29c. LICE	ENSE NUMB	SER 40		29d. DATE S	SIGNED (	Month, Day, Year)	
10	10	30. NAME AND ADDRESS OF I	PERSON WHO	COMPLETED CAU	1	10	, Print)		2/4	رون		nd	2		132	
		MAY "0"2"1995"	Jelia Jelia	distant	September 1	IRE				- (						



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DIVISION OF VITAL RECORDS, P.O. BOX 68760	TENDED PHYSICIAN: The law requires that the death certificate be executed with
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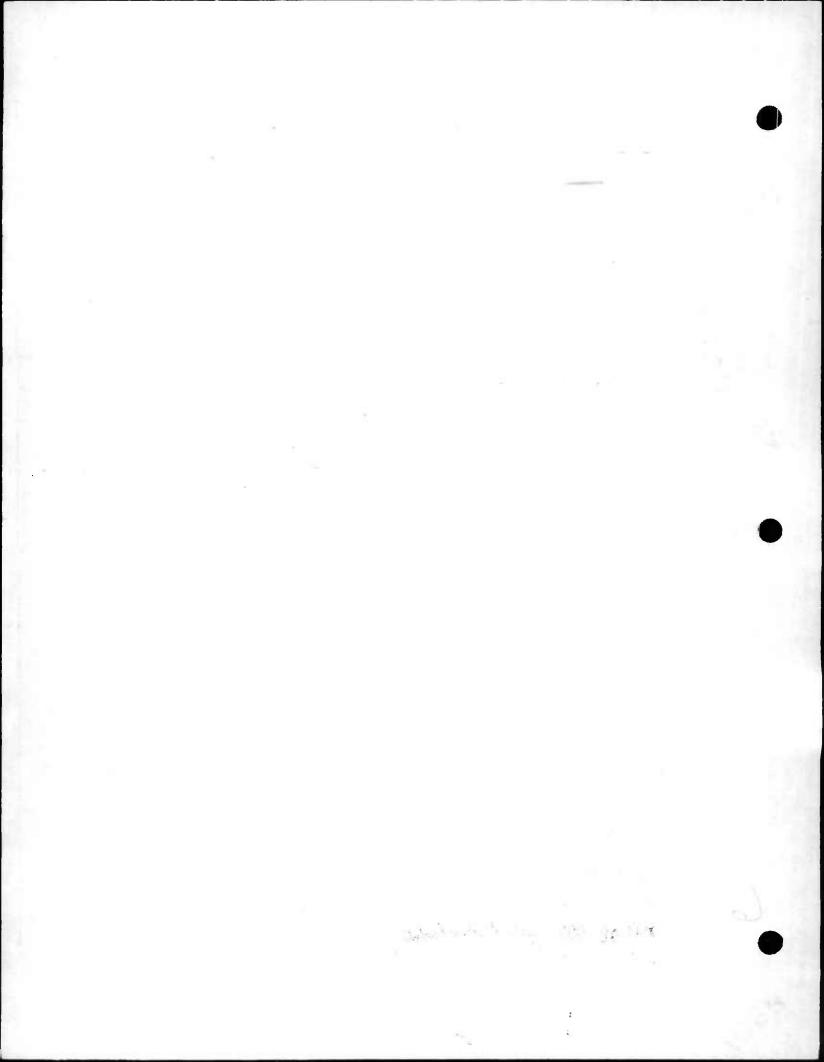
	FOR		07177 OF -										95	)	3200	
	1 - STATE REGISTRAR		STATE OF I	MARYLA	ND / DEF	EPAR	TMENT O	OF	DEAT	AND I	MENT	AL HYGIE				
1	1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DE			3. TIME OF DEAT	н	
	MARION  4. SOCIAL SECURITY NUMB	F 5. SEX	10.000 (		FUL					April 27, 1995			3:55	P M		
			5. SEX 1.⊠MM 2 □ F		yrs. lest bir		MONTHS D	EAR AYS	HOURS	24 HRS.	(Mo	TE OF BIRTH		8. BIRTH Count	HPLACE (State or For ry)	reign
	217-14-557 90. FACILITY NAME (If not ins			12			9b. CITY TO	9b. CITY, TOWN OR LOCATION OF DEAT		Aug. 26, 1922		NTV OF D	Md.			
<u>۳</u>	Manor Care					Towson							sc. 000		timore	
اق	RESIDENCE OF DEC	EDENT 10b. COUNTY									Dal					
DIRECTOR	Md.		ltimore		,	10c. CITY	, TOWN OR L								10d. INSIDE CITY LIMITS?	
	10a. STREET AND NUMBER	De	TUTHOLE		Timon			ON LUM				10g, CIT	IZEN OF Y	1 TYES 2 2 1	NO	
FUNERAL	#1 Gurte	en Ct.								2109:	3			II.S		
5	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1			D	13. WAS	DECE	ENDENT C	F HISPAN	HC ORIG	MN? (Specify Y	a or No-	14. RACI	E — American India k, White, etc.	n,
B	1 Never Married 2 X 3 Widowed 4 Divor	I TO STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE	IF YES, GIVE Y	MAR OR DAT					2 KNO					Spec	tty:	
		EDENT'S EDUC	CATION	TION 180, DECEDE			USUAL OCCU	PATIO	N		16b. KIND OF BUSINESS/INDUST		DUSTRY	White		
	(Specify only Elementary/Secondary (0-	highest grade	College (1-4 or 5		(Give I	(Give kind of work done during most of working life. Do NOT use retired.)					16b. KIND OF BUSINESS/INDUSTRY					
COMPLETED			2		Bric.	k La	ayer				Fulco Construction			ion		
	17. FATHER'S NAME (First, Middle, Leet)  Joseph Fulco						872					ME (First, Middle, Melden Surneme)				
	19e. INFORMANT'S NAME (Type/Print)					LAIL INC	Lucia Daniela  ILING ADDRESS (Street and Number or Ruhal Route Number, City or Town, State, Zip Code)									
TO B	Mrs. Marie	i i									(Code)					
	20a. METHOD OF DISPOSITION    Gurial 2   Gremation 3   Removal from State   Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory or other place    Commetter, crematory															
	4 ☐ Donation 5 ☑ Other	(Specify) ET	tombment	Du.	tary, cramati Lanev	fory or oth 7 Va	ner place) lley l	Men	ı. Gö	ins.	5/2/	'95 Ti	moni	ım, N	1d.	
	21. SIGNATURE OF FUNEDAL	- BERNICE LIC	CH C	)			22. NAN	AE ANI	D ADDRES	SS OF FA	CILITY	eral F				
a second	$-d\omega$	2	SURVE	٧.				_				owson,				
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, ahock, or heart fellure. List only one cause on each fine.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Due to (or as a conscouence of):  Diagram Approximate interval Between Onset and Death  Due to (or as a conscouence of):  Sequentially list conditions,															
AL CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):															
DIC	PART II. Other algorificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part 1. 24a. WAS AN AUTOPSY PERFORMED?  1 VES 2 IN NO								24b.	WERE AUTOPSY FIN AMILABLE PRIOR T COMPLETION OF CA OF DEATH?	0					
ME	DID TODA GGO IV										/				1   YES 2   N	0
PHYSICIAN: MED	DID TOBACCO US		IBUIE IO CA		_		(Check only		UNC	ERTAIN	1 0	7.7				
YSICI	EXAMINER?		HOSPITAL:				OTHER:	<u> </u>		-14						$\neg$
Ě	27. MANNER OF DEATH		28e. DATE OF	INJURY		8b. TIME	OF 280	. INJU	IRY AT	sidence		ESCRIBE HOW	INJURY OC	CURED		$\dashv$
ВУР		Pending Investigation	(Month, D.	wy, rowr)		INJU	4.4	WOR	RK7 ES 2 [	NO						
ETED B	3 Suicide 8 C	Could not be letermined	28e. PLACE O building,	F INJURY atc. (Specify	At home,	farm, at	rm, street, factory, office				281. LO	CATION (Street y or Yown, State	end Number	or Rural F	Poute Number,	
릴			CIAN: To the best of R: On the bests of ea												) and manner ea sta	ited.
O BE COM	296. SIGNATURE AND TITLE	OF CERTUFJER	00	1	1				29c. LICE	NSE NUM	IBER		29d. DAT	E SIGNEO	(Month, Day, Year)	
2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAL	RE OF DEAT	A (ITEM 27	7) (7000	Print)		1	>4/	2	)		+/2	8/75	
	James Ebel			/	M		owson	7.4	12 2	120/	1			/	l	
	31. DATE FILED (Month, Day, Y	bar)	32. REGISTRA	R'S SIONAT		• I	OWSUII	, IV	iu. 2	.1204	±				-	
1 11	MAY U 2 19	45 X	the distribution		14.14											- 1

Item # 9 Film # G 723 5-2-95 N.A. Per Funeral Home

SION OF VITAL RECORDS, P.O. BOX 68760	BALTIMORE, MARYLAND 21215-0020
FENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	hours after death. Page 6 may be retained by the hospital or attending physician.
OR: After this certificate has been signed by the attending physician and completely filled in by the fifter the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	OR: After this centificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should for death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.

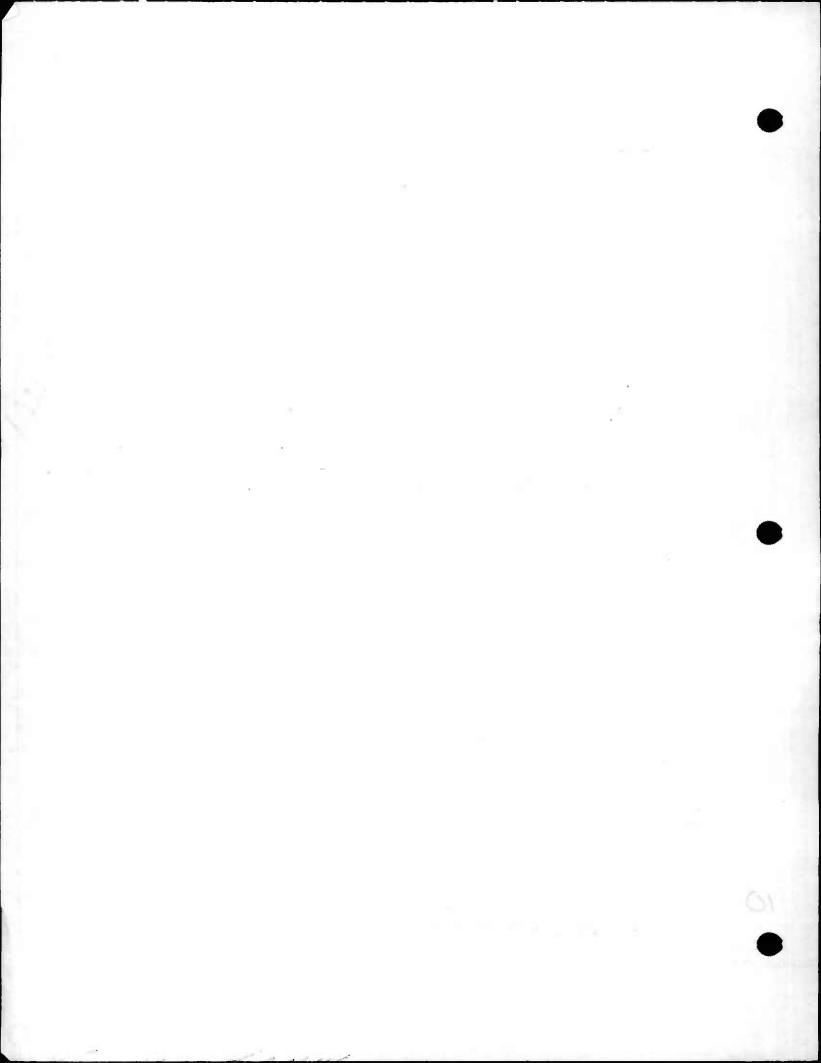
1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. REG NO.

		1. DECEDENT'S NAME (First, Middle, La		_				1	DATE OF DEATH	DAY	3. TIME OF DEATN	
		WILLIAM	SWOP			FIS	HER J	0	PRIL	95 3:45A M		
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I		MONTHS DAY	_				BIRTHPLACE (State or Foreign Country)	
P) 20		218 → 62 → 4487  Se. FACILITY NAME (If not institution, girl	1 💢 M 2 🗆 F	41	YRS.				DATE OF BIRTH (Month, Day, Year) Sept. 1:	2,1953	Maryland	
3 %	ا <u>د</u>	7842 STREET		DRIVE			N OR LOCATION	N OF DEATN			NTY OF DEATH LT IMORE	
1, 2,	FUNERAL DIRECTOR	RESIDENCE OF DECEDENT								Dis	BI ITTOKE	
Pages		Maruland 10b. COU	NTY Baltimo	4.0	10c. CIT	Y, TOWN OR LO		l 0 la			10d. INSIDE CITY LIMITS?	
armit.		Maryland 100. STREET AND NUMBER	Бассино	re	1		101, ZIP CODE	idalk		100 CITI	1 TYES 2 NO	
physician. burial-transit permit. Pages 1, 2, 3 should		7842 St. Gregor	y Drive					21222	?	10g. CITIZEN OF WHAT COUNTRY?  United States		
physician burial-tra		11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDER	T EVER IN U.S. A	RMED				PRIGIN? (Specify perto Rican, atc.)	Yes or No-	14. RACE — American Indian, Black, White, etc.	
말	B	3 Widowed 4 Divorced	IF YES, GIVE	MAR OR DATES				Specify:	orto mosti, stal		Specify: White	
r attending use as the	9	15. DECEDENT'S E (Specify only highest gr	DUCATION Ide completed	16a. D	ECEDENT'S	USUAL OCCUP	ATION		16b. KIND OF I	BUSINESS/IND		
o a o		Elementary/Secondary (0-12)	College (1-4 or 5	+}		110-2	most of working					
the hospital detached for once.	TO BE (	12 Years  17. FATHER'S NAME (First, Middle, Lest)		W.	cre M	esh Li			wire i		ry	
2 % To		William S. Fish	IOH SH.						First, Middle, Meid Viklinst	-,		
5 should notified		19a. INFORMANT'S NAME (Type/Print)		1	9b. MAILING	ADDRESS (Stra			Number, City or 1		Code)	
		Maria Fisher							Baltin			
leath. Page 6 may be funeral director, page xaminer must be		20a. METHOD OF DISPOSITION 1 Device 2 Cremation 3 R	amoval from State	20b. PLACE cornetery, cr	AND DATE (	OF DISPOSITION	(Name of	4.400	DATE 20c.	LOCATION —	City or Town, State	
Page (al direct		4 ☐ Donation 5 ☐ Oyer (Specify) 21. SIGNATURE Of FUNERAL SERVICE	LICENSEE	Hill	top S	ervice 22. NAME	COTP.	4/29/	95 10	wson,	Maryland	
death. Pag e funeral dir J. examiner		A Comment	0	10	1	Du	la-Ruck	Fund	iral Hon	ne 06 1	Dundalk, Inc.	
0 = 0		23. PART I. Enter the dispases, t	v compaliantians the	ceed	<u> </u>						D 21222	
d in		anock, or near rand	e. List only one car	ise on each lin	eath. DD r	ot antar tha	moda of dyln	g, such as	cardiec or rea	ipiratory em	Intarval Between	
24 ign, ign		IMMEDIATE CAUSE (Final disease or condition		MULIA	- 01		TA AT				Onset and Death	
rted within 24 completely fill ial, cremation,		resulting in death)	DUE TO	OR AS A CONSE	OUENCE OF	F):	Ly	OCVO				
	NO	Sequentially list conditions,	b									
be estician a dior to traum	ATI	If any, leading to immediate cause. Enter UNDERLYING	DUE TO	(OR AS A CONSE	QUENCE OF	F):						
h certificate be execute and conding physician and conding physician and conditions or other traumatic	E S	CAUSE (Disease or Injury that initiated eventa	CDUE TO	(OR AS A CONSE	QUENCE OF	F):						
	CERTIFICATION	reaulting in deeth) LAST	d									
the atter Mental Mjury, o	L C	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS										
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sign Sign Healt	MED								W'ES	4 [] NU	OF DEATH?  VES 2 □ NO	
law re as bee lept. o	N.	DID TOBACCO USE CON	ITRIBUTE TO CA					RTAIN [			-	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requitor THE FUNEPAL DIRECTOR: After this certificate has been be filed within 72 hours after death with the State Dept. of IMPORTANT: If Item 28 is marked, or Item 23 sho	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  XX YES 2 \( \text{\subset}\) NO	HOSPITAL:			OTHER:						
Sicial certificant the S	HYS	27. MANNER OF DEATH	1 Inpetient 2 I	INJURY	28b. TIM	4 - Nursing N	ome 5 Resident		Other (Specify)	A INTINIBA OCC	IDED	
or this th with	BY PI	1 Natural 5 Pending 2 Accident Investigatio	(Month, E	195	020	URY	WORK?	0	eduto	in the	Mch vehile	
R. After dear dear		3 Suicide 6 Could not t	28e PLACE C	F INJURY — At h	ome, larm, s	street, fectory, o	ffica	281	LOCATION (Street	et end Number	or Rural Route Number,	
RECTO	ETE	4 Nomicide datermined		"Si	Per				7723	- Greg	on dr.	
AL OF AL DIF 72 hou	AP.	29a. CERTIFIER  1 CERTIFYING PN	SICIAN: To the best of	my knowledge, d	eath occurre	d at the time, d	eta and piece, a	and due to th	ne cause(s) end n	nenner as state	od.	
HOSPI UNER VITHIN ANT:	COMPL	A financial and a second		xamination end/or	Investigation	n, in my opinio	, death occured	f at the time.	, date end place,	end due to the	e ceuse(a) and menner as stated.	
PORT Y	BE	SIGNATURE AND TITLE OF CERTIF	ien la Mí	)				SE NUMBER			StGNED (Month, Day, Year)	
2 2 3 3	5	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CALL	SE OF DEATH //TE	M 27) /Kina	Print)	1 0	O.C.M	.E.	AI	PRIL 27/95	
		J. LARON LOCKE		111			er e	<u> </u>	MORF	MADVI	LAND 21201	
0		31. DATE FILED (Month, Day, Year)	20, REGISTRA	R'S SIGNATURE		TA DIM	L	WILL	TIONE,	1.141/11	DAND ZIZUI	
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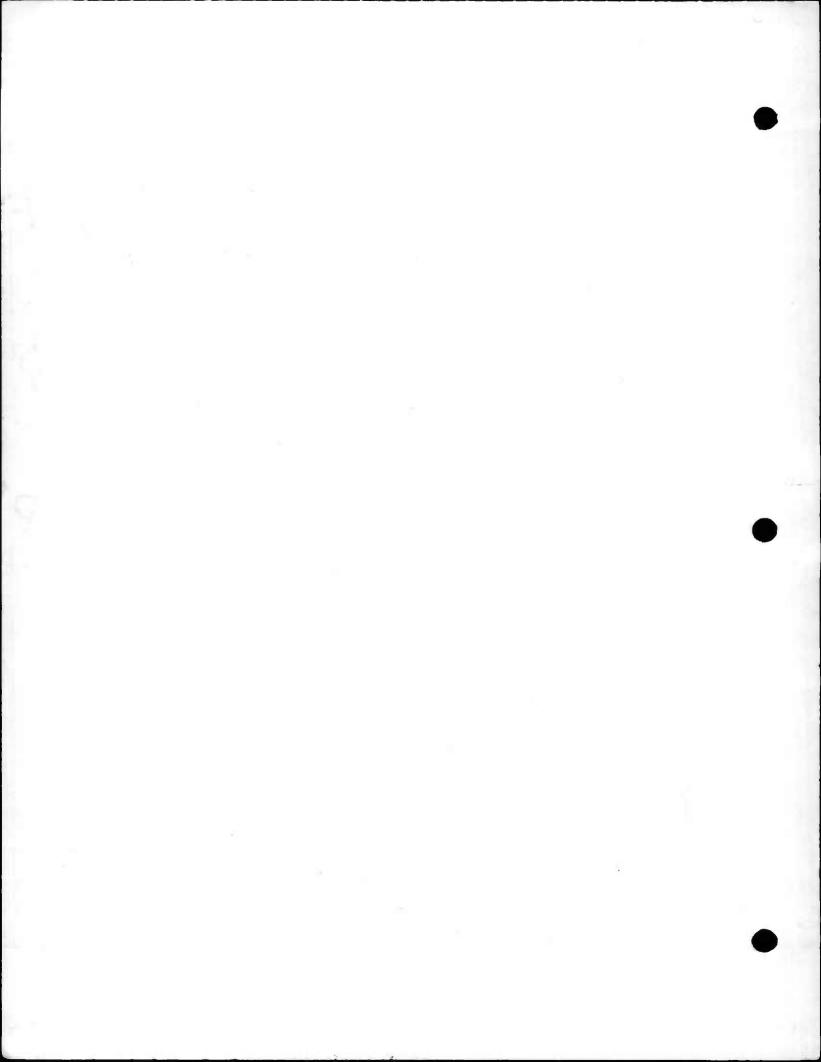
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		1 - FOR STATE REGISTRAR	STATE OF MARYLAN		RTMENT OF			GIENE 3. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)	Elmer Wood	guson	2. DATE OF DE	22:17 M					
		4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In y	rs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	RS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign				
Pin	L DIRECTOR		1 □2 M 2 □ F   80	YRS.	MONTHS DAYS	HOURS MIN.		7,1914 (	Vest Virginia		
, 3 should		90. FACILITY NAME (11 not institution, give stra Johns Hopkins Bay	view Medical	Ctr.		imore ci		9c. COUNTY	Y OF DEATH A		
5, 2,		RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY						1 1 1 1 7 7			
nit. Pages		Maryland	Baltimore	10c. Cri	Y, TOWN OR LOCA		gemere		10d. INSIDE CITY LIMITS? 1 YES 2 NO		
ı. ınsit permit.	ERAL	100. STREET AND NUMBER 2814 Wells Avenue	2		1	01. ZIP CODE 21 21	19	,	n of what country? ed States		
215-0020 attending physician. ise as the burial-transit	COMPLETED BY FUNER	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	2016o	If yes, s	CENDENT OF HISPA pecity Cuban, Mexico S 2 1 NO Specia	en, Puerto Rican, a	offy Yea or No- 14	Black, White, etc.  Specify: White		
or attending		15. DECEDENT'S EDUCA (Specify only highest grade of	ATION 16		USUAL OCCUPAT		16b, KIND	OF BUSINESS/INDUS			
ital or		Elementary/Secondary (0-12)	College (1-4 or 5+)	Ilfe. Do NOT u	se retired.)		04.	0 T.J.	4		
the hospital detached to once.		17. FATHER'S NAME (First, Middle, Last)		Steel	worker	Welder	STO	zel Indus	Viy		
ज देव	l iii l	Park C. Ferguson				Theodo.		unknown			
be retained ge 5 should e notified	TO B	19e. INFORMANT'S NAME (Type/Print) Steve L. Ferguson Danald F. Ferguson	n	196. MAILING 31 01 U 2814	ADORESS (Street			or Town, State, Zip Co 1 MD 2121	758		
		20e. METHOD OF DISPOSITION 1	rel from State 20b. PL.	ACE AND DATE	OF DISPOSITION (A	lame of	DATE	Oc. LOCATION - City	v or Town, State		
		4 Donation 5 DOther (Specify) EV.	tombment Ga	rdens c	Faith	Maus. 4	/29/95	Baltimor	e, Maryland		
SALT death. r death. e funera al. examil		Lregon	E. Reed	_	7922	-Ruck Full Wise Av	neral Ho e. Duno	ome of Du dalk, MD	ndalk, Inc. 21222		
hours after ed in by the or removal		23. PART i, Enter the diseases, or or shock, or sease failure.	mplications that ceused th at only one cause on eech	e deeth, Do i	not enter the m	ode of dying, aud	ch aa cerdiec o	reepiratory arres	t, Approximata		
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ompletel completel al, crema			DUE TO (OR AS A CO	NSEQUENCE O	F):				YEARS		
X 68 be execut ian and c in to buri	CERTIFICATION	Sequentially liet conditions, if any, leeding to immediate	DUE TO (OR AS A CO	NSEQUENCE O	F):				1246>		
tificate to physiciene priore priore tractions that the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions are the tractions	IFICA	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa	DUE TO (OR AS A CO	NSEQUENCE O	F):						
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L RECORD law requires that the ss been signed by th lept, of Health and N 23 shows any inj	MEDICAL						YES 2 NO	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
RECO  w requires th  been signed  r. of Health  shows an		DID TOBACCO USE CONTR	BLITE TO CALISE OF I	SEATU VI	S CI NO F	UNCERTAI	NI IO		1 TYES 2 NO		
AL Me law he law has be bept.	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			TH (Check only one		N DS				
VIIAN: The Clan: The State the State to or Item	Sic		HOSPITAL:	nt 3 🗆 DOA	OTHER: 4 Nursing Ho	me 5 🗆 Residence	6 Other (Speci	(fy)			
HYSICI HIS Cer	PH	27. MANNER OF DEATH  1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM		JURY AT ORK?	28d. DESCRIBE	HOW INJURY OCCUP	(ED		
ING PHYS Wher this consumer that	BY	Accident Investigation	28. DI ACE OF IN HUNY	11 12 12 12 12 12 12 12 12 12 12 12 12 1		YES 2 NO					
OF VITAL OR ATTENDING PHYSICIAN: The DIRECTUR After this certificate his hours after death with the State D INNERS IN MARKET, OF IREM	H	Suicide 8 Could not be determined	26e. PLACE OF INJURY — j building, etc. (Specify)	at nome, sarm,	mreet, rectory, orn	Rural Route Number,					
전 경압 등	M		AN: To the best of my knowledg								
HOSPITAL FUNERAL WITHIN 72 RTANT: II	E CO	THE SIGNATURE AND NITLE OF CONTIFIER				29c. LICENSE NU			MED (Month, Day, Year)		
TO THE HOSPITAL TO THE FUNEFIAL be filed within 72 IMPORTANT: II	100	C 2for	M			D250	203	4-1	27/95		
12	5	30. NAME AND ADDRESS OF/PERSON WHO						+			
10		Christopher Morr	ow MD 4940 Ea	stern	Avenue	Baltimor	e, Mary	land 212	:24		
		MAY 02 1995	34 REGISTRAR GIGNATU	ζ*							

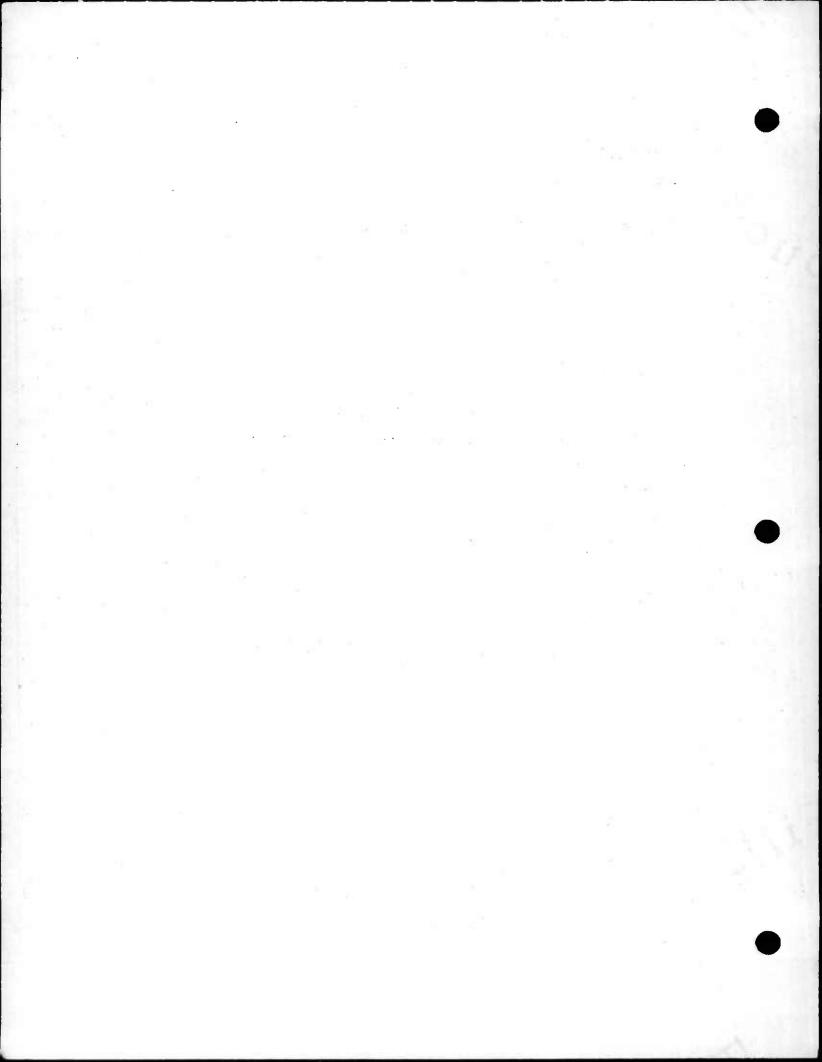


## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

			REGISTRAR		CERTIF	ICATE OF	DEATH		REG. NO.		
			1. DECEDENT'S NAME (First, Middle, Last)	Felde	- D			2. DATE OF MONTH		EAR	TIME OF DEATH
			4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (	(In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF (Month, D	BIRTH S.		ACE (State or Foreign
physical			90. FACILITY NAME (If not institution, give s	treet end number)	YRS.	9b. CITY, TOWN	OR LOCATION OF D		26-6/ B	OF DEAT	
0	,	TOR	Jeton H. 11 /	MAnon		Baltin	RE, MO	(	BALI	1, m	TRE
Parait Parait		FUNERAL DIRECTOR	10e. STATE 10b. COUNTY	Balto	10c. CIT	Y, TOON OR LOCA	TION			10	d. INSIDE CITY LUMITS?  YES 2 NO
, tel			4602 Bel	Vieu A	ve		212	07	U	OF WHA	T COUNTRY?
21215-0020 all or attending physician. for use as the burdat-maneit		B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, DIVE WAR OR DA	2 NO	13. WAS DEC If yes, sp 1 — YES	ecity Cuben, Mexico 2 NO Specif	n, Puerto Rice	Specify Yee or No— 14.	RACE — Black, W Specify:	American Indian, hite, etc.
1215-0 or attending		ED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a, DECEDENT'S	USUAL OCCUPATE work done during mo	ON set of working	18b. KI	ND OF BUSINESS/INDUS	<b>TRY</b>	
Spital or		COMPLET	Elementery/Secondary (0-12)	College (1-4 or 5+)	Dr. 1	se retired.)	ssistan	47	on Brown	۸ 6	Engineering
MARYLAND 2 retained by the hospital 5 should be detached to	at once.		17 FATHER'S NAME (First, Middle, Last)	Idec			18. MOTHER'S NA		lle, Maiden Sumeme)	0.0	
MAR retained to 5 should	notified	) BE	190. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street,		nice Route Number,	City or Town, State, Zip Co	de) a	
		2	Ungela -	etephens	460:	2 Bel	vien A	ve	Balto, M	od 2	21207
BALTIMORE, er death. Page 6 may be the funeral director, page	ı must		1 Burlet 2 Cremetion 3 Remo	oval from State cer	PLACE AND DATE	of disposition (Ne	atory	5/4/4	20c. LOCATION - CHY	or Town,	1
ALTIMO death. Page funeral direct	i. examiner		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		22, NAME AI	ND ADDRESS OF EA	CILITY - U	vest		
BAI after dea	- e		Dladus	Waner	<u> </u>	143	00 h	Ja ba		e	
urs af	edic		23. PART I. Enter the diseases, or of shock, or heart fallure.	complications that caused List only one cause on a	the deeth. Do i	not enter the mo	de of dying, suc	h es cardiac	or respiretory screet	,	Approximate Interval Between
42 章	ion,		IMMEDIATE CAUSE (Finei diseese or condition	1	0 1		N. 1. 1		S		Onaet and Death
1760, ted within	cremation, vent, the		resulting in death)	DUE TO (OR AS A	CONSEQUENCE O	nmune o	Deficie	nay	Syndrome	_	months
executed within and completely	traumatic event,	Z	Sequentially list conditions,	b							
	ior to	CERTIFICATION	If sny, leading to immediate ceuse. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE O	F):					
O. B. certificate ding physi		JE I	CAUSE (Disesse or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE O	F):					
وَ جِ ہ	£ 9	ERI	resulting in deeth) LAST	d							
	d Mental Injury, o	- 11	PART II. Other significant condition	e contributing to death b	ut not resulting	In the underlying	g ceuse given in	Part I. 24	a. WAS AN AUTOPSY	24b. WE	RE AUTOPSY FINDINGS
CORD  ires that the signed by the	any	DICAL						_ 1	PERFORMED?	co	MPLETION OF CAUSE DEATH?
REC requires een sign	shows	ME									YES 2 NO
- 1 × 2 × 2 × 2 × 2 × 2 × 2 × 2 × 2 × 2 ×	23 Pep	AN	DID TOBACCO USE CONTR				UNCERTAI	<u>ч 🗆                                   </u>			
N: The	State	SICIAN:	EXAMINER?	HOSPITAL:	28. PLACE OF DEA	OTHER:	500.41	4.00			
SICIA Certif	d, or	È∥	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TJM	E OF 28c. INJ			BE HOW INJURY OCCUR	ED	
N O N IG PHY	death with	A P	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INS		PRK? YES 2 NO				
DIVISION OF VITA HOSPITAL OR ATTENDING PHYSICIAN: The FUNERAL DIRECTOR: After this certificate in	alle a	ETEO	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, ferm,	atreet, fectory, offic		28f. LOCATIO	ON (Street and Number or I own, State)	iural Route	Number,
RAL OF AL DIF	2	7		CIAN: To the best of my knowl							
HOSPI	within 72	COM		R: On the basis of examination	n end/or investigation	on, In my opinion, d			d piece, end due to the co	iuse(e) an	d menner es atated.
黒黒	be filed within 7	H	296. SIGNATURE AND TITLE OF CHATIFIES	nul at	tending	physician	29c. LICENSE NUI	MBER	29d. DATE SI	GNED (MO	onth, Day, Year)
2 2	ੜ ≧	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE			1)341	20	1, 3	1110	
1			Jyotin Parik	h, mp 82		law Ste	est Sui	te 40	7 Baltimo	ee	MD 21201.
			MAY U 2 1995	32. REGISTRAR'S SION	ATURE				1		



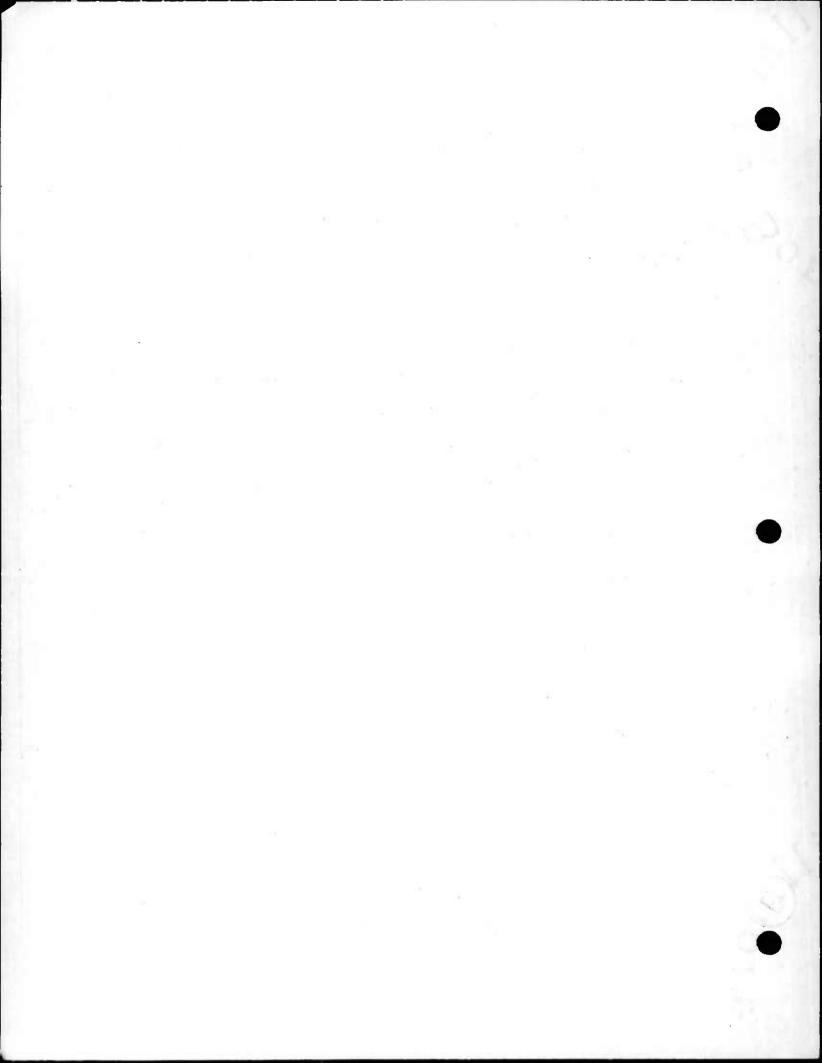
	1 - STATE REGISTRAR	STATE OF MARYLA		TMENT OF		MENTAL HYGIEN REG. NO.	E					
	1. DECEDENT'S NAME (First, Middle, Lest)  Margaret Eve	Frink				2. DATE OF DEATH PORTIL 2	8 1§	3. TIME OF OEATH 8:10 P. M				
	027-01-6291	1 □ M 2 🗓 F 85	n yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS		7. DATE OF BIRTH (Month, Day, Year) January 18		BIRTHPLACE (State or Foreign Country) Mass.				
90	9e. FACILITY NAME (If not Institution, give street Medbridge Medical &	of DEATH										
DIRECTOR	10a. STATE 10b. COUNTY			Y, TOWN OR LOC	ATION			10d. INSIDE CITY LIMITS?				
A P	Maryland N	N/A	IBalt	imore	Of. ZIP CODE		10g. CITIZE	1 ✓ YES 2 ☐ NO N OF WHAT COUNTRY?				
FUNER	3022 Northern Park	WAY	U.S. ARMED	12 WAS DE	21214	NIC ORIGIN? (Specify Yes	U,S	.A.				
B	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 YES	2 NO	or No-   14	. RACE — American Indian, Black, White, etc. Specify: White							
LETED	15. DECEDENT'S EDUCAT (Specify only highest grade col Elementary/Secondary (0-12)		(1-4 or 5+) life. Do NOT use retired.)									
at once.	17. FATHER'S NAME (First, Middle, Last)		Teacher Balto. C									
10 m	William M. Smith		Programme		Bessie	C. Flave						
De notified TO BI	19b. INFORMANT'S NAME (Types/Print)  Pamela Ziomek  19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  8658 Castlemill Circle - 21236											
must b	20a. METHOD OF DISPOSITION 1 (X Burlel 2 Cremation 3 Generally Community Control of Community Control of Community Control of Community Control of Community Community Control of Community Control of Community Control of Community Control of Community Community Control of Community Control of Community Control of Community Control of Community Control of Community Control of Community Control of Community Control of Community Control of Community Control of Community Control of Community Control of Community Control of Community Control of Community Control of Community Control of Community Control of Community Control of Community Control of Community Control of Community Control of Community Control of Community Control of Community Control of Community Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Contr											
examiner must	21. SIGNATURE OF FUNERAL SERVICE VICENSEE  22. NAME AND ADDRESS OF FACILITY FUNERAL HOme, Inc. 5305 Harford Rd. Balto. Md. 21214											
medicai	23. PART I. Enter the diseases, or con ahock, or heart fallure. Lie	nplicetions that caused it only one ceuse on as	the dasth. Do n									
the in	IMMEDIATE CAUSE (Final disease or condition resulting in death)  Due to (or as a consequence or):  ESSENTYAL HYPERTENSION  Sequentially list conditions.											
9	Sequentially list conditions,  Sequentially list conditions,  Sequentially list conditions,											
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or other	CAUSE (Disease or Injury that Initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):										
AP AP	PART II. Other significant conditions of	contributing to death bu	it not resulting i	n the underlyli	ng cause given in	Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO				
MED A					1 □ YES 2	Mo	COMPLETION OF CAUSE OF DEATH?					
23 show	DID TOBACCO USE CONTRIE					<u> </u>		i les aprilo				
ed, or item 23 si PHYSICIAN:	EXAMINER?	1OSPITAL:	6. PLACE OF DEAT	OTHER:	me 5 🗆 Residence	8 Other (Specify)						
2 6	27. MANNER OF DEATN  1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIMI	URY W	JURY AT ORK? YES 2 NO	28d. DESCRIBE NOW IN	JURY OCCUR	ED				
28 is ma	3 Suicide 8 Could not be 4 Nomicide determined	28e. PLACE OF INJURY - building, atc. (Specif)	— At home, farm, a	treet, fectory, offi	ce	281. LOCATION (Street a City or Town, State)	nd Number or I	Rural Route Number,				
ME I Item 2	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: (	IN: To the best of my knowle On the basis of examination	dge, death occurre	d at the time, dat n, in my opinion,	in and place, end due death occured at the	to the cause(s) end man time, date end piece, and	ner es stated. I due to the c	euse(s) end menner es atated.				
	296. SIGNATURE AND TITLE OF CERTIFIER	un n	ND		29c. LICENSE NUM	30641	29d. DATE SI	GNED (Month, Day, Year)				
0	30. NAME AND AGORESS OF PERSON WHO C	OMPLETEO CAUSE OF DEAT	TH (ITEM 27) (Type,	Print) E V	TAW.	ST BA	LNM	reEM02pol				
	MAY U 2 1995 July	32. REGISTRAR'S AIGNAT	TUDE									



BALTIMORE, MARYLAND 21215-0020	ours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should thin the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	nedical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fun the first within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	

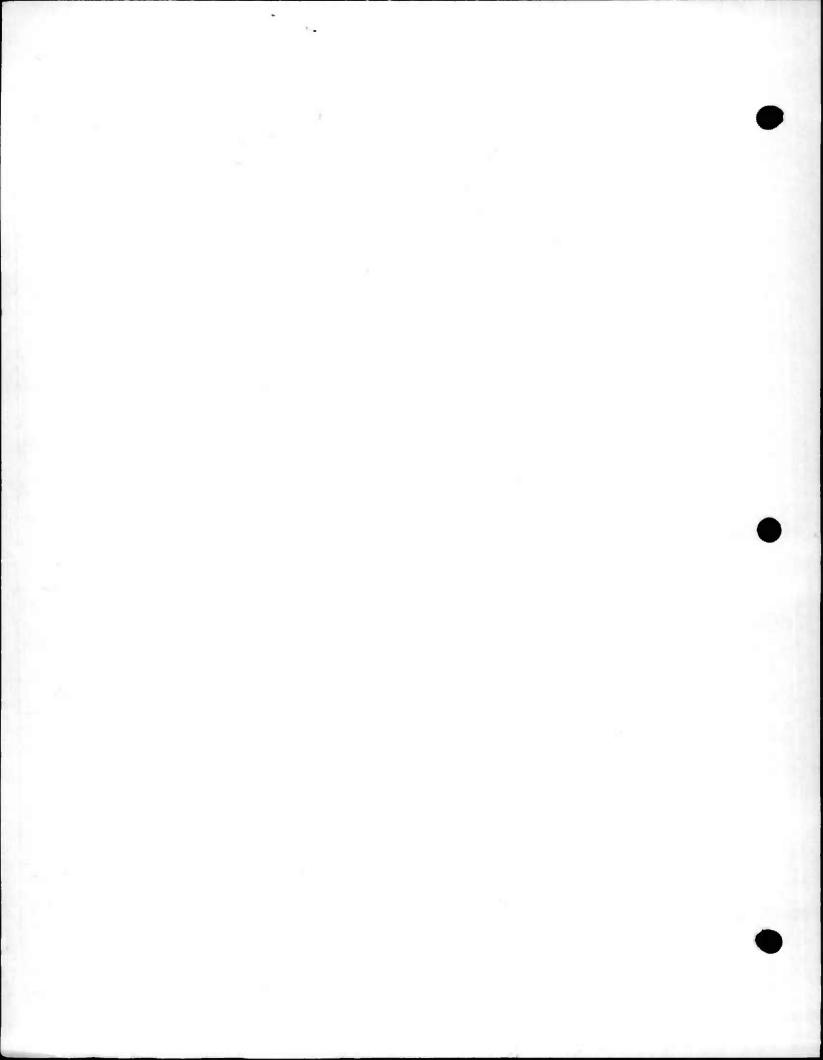
1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR		CEI	TIFIC	AIE OF	DEATH		REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) Nicholas James	Fotos						ATE OF DEATH	* 1 0 0	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER		E (In yrs. lest b	fat de la m	IF UNDER 1 YEAR   IF UNDER 24 HRS.			ril 27	, 199	5   11:45a M		
	219-16-0108	1 NM 2   F	70		NTHS DAYS	HOURS MIN	7. D/	ATE OF BIRTH	224	8. BIRTHPLACE (State or Foreign Country)		
	9e. FACILITY NAME (If not institution, give a		70							24 Maryland		
œ					9b. CITY, TOWN OR LOCATION OF DEATH					NTY OF DEATH		
5	Anne Arundel Me	edical Cer	iter_		Annapolis					ne Arundel		
DIRECTOR	10e STATE 10h COUNTY	Arundel		10c. CITY, T	OWN OR LOCA	TION				10d. INSIDE CITY		
	Anne	Arunder		Annapolis					1X YES 2 NO			
₹	10e. STREET AND NUMBER			101. ZIP CODE 10g. 0					10g. CITI	TIZEN OF WHAT COUNTRY?		
FUNERAL	149 Monticello					214	01			USA		
Ē	11. MARITAL STATUS  1 Nover Merried 2 Married	12. WAS DECEDENT EVER FORCES? 15 YES						or No-	No— 14. RACE — American Indian, Black, While, stc.			
BY	3 Widowed 4 Divorced	IF YES, OIVE WAR OR	DATES			2 □XNO Sp		ito thous, star,	- 1	SpecHy: White		
	15. DECEDENT'S EDU	CATION	18e DECE	DECEDENT'S USUAL OCCUPATION 166, KIND OF BUSINESS/INDI						MATAN		
ET	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give		done during mo			IOU KIND OF BOS	INESS/INL	OSTRY		
7	12	5+	Lav	vyer				Ger	era	l Law		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S	NAME (Fir	st, Middle, Meiden S				
BE (	James		Fot	tos		Ale	xan	dra	P	etroginas		
0	19e. INFORMANT'S NAME (Type/Print)							lumber, City or Town				
F	Christine	Fotos	149	) Moi	ntice:	llo Av	enue	e, Anna	apol	is, MD 21401		
	28a, METHOD OF DISPOSITION  1 To Burlel 2 Cremetton 3 Rem		Ob. PLACE AND		ISPOSITION (Ne	ame of		ATE 20c. LOC	CATION —	City or Town, State		
	4 Donation 8 Other (Specify)	S	t. De	emet	rius (			.4/29	Ann	apolis, MD		
	21, SIGNATURE OF PUMERAL BERVICE GO	7///				ND ACCRESS OF		ral Hom	10	D A		
	· Date fleet											
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory erreat, ahock, or heart feliure. List only one ceuse on each line.  Approximate interval Batween											
	interval Batween immediaTe CAUSE (Final											
	DUE TO (OR AS A CONSEQUENCE OF):											
Z	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											
Ě										1.100		
CERTIFICATION	cause, Enter UNDERLYING CAUSE (Disease or injury the full lated owners)  DUE TO (OR AS A CONSCOUENCE OF):									1 well		
E	that initiated eventa DUE TO (OR AS A CONSEQUENCE OF): reaulting in deeth) LAST											
S									-			
AL	PART II. Other significent condition	a contributing to death	but not resu	uiting in t	he Underlying	g cause given	in Part i	24a. WAS AN A		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
MEDICAL				PERFC 1   YES						COMPLETION OF CAUSE OF GEATH?		
M								1 '		1 TES 2 NO		
ÿ	DID TOBACCO USE CONTI	RIBUTE TO CAUSE	OF DEATH	YES	□ NO □	UNCERTA	NN 🗆					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSFITAL:	26. PLACE C		Check only one)							
YSI	1 VES 2 NO	1 Inpetient 2 - ER/Ou				e 5 🗆 Reeldend	e 8 🗆 O	ther (Specify)				
	27. MANNER OF DEATH  1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)		8b. TIME OF		URY AT	28d.	DEŞCRIBE HOW IN	JURY OCC	UREO		
B	2 Accident Investigation				YES 2 NO							
8	3 Suicide 6 Could not be 4 Homicide determined	, farm, stree	t, factory, office	•	28f. L	OCATION (Street ar City or Town, State)	nd Number	or Rural Route Number,				
<u>L</u>	20. 0000000											
호	(Check only	CIAN: To the best of my kno										
COMPLETED	2 MEDICAL EXAMINE	R: On the basis of examinati	on end/or Inve	atigation, in	my opinion, d	eath occured at t	he lime, d	late end plece, end	due to the	s couse(s) end manner se stated.		
	2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the lime, date end piece, end due to the ceuse(e) end manner se stated.  29b. SIGNATURE AND TITLE OF CERTIFIER  29c. LICENSE NUMBER  29d. DATE SIGNED (Montly, Day, Year)											
20 1	O	Quiller   046462   1/88/11										
O BE	ansen	-				046	90			115		
TO BE	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF O				046	96	.1		1/5/9/		
	Alan Weiss	139 01	dic	o (on	MCI :	III I	2d	Anna	poli	MO 21401		
	30. NAME AND ADDRESS OF PERSON WHO ALCO WELLS 31. DATE FILED (MONTH, Day, Year)	139 01	dic	o (on	MCI :	III	2d	Anna	poli	1 MO 3 1401		



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			1 - STATE REGISTRAR	STATE OF MARYI	LAND / DEPAR CERTIF	RTMENT OF ICATE OF	HEALTH AND	MENTAL HYGIEN				
		i	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF GEATN		year 3. TIME OF DEATH		
			4. SOCIAL SECURITY NUMBER	K			ANEL	1.71.14	26 9	15 4:25PH		
			219-28-4896	5. SEX 6. AGE	(In yrs. lest birthday) 66 YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		B. BIRTHPLACE (State or Foreign Country)		
should			9a. FACILITY NAME (If not institution, give s		00 1110.	9b. CITY, TOWN	OR LOCATION OF D	6-20-29	T 9c. COUNT	Y OF OEATN		
2, 3 st	8	5	Good Samaritan Ho		Raven B		Baltimo		Sc. COOK	TOF SEATN		
4-7	[		RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY									
permit. Pages	2	DIRECTOR	Maryland			altimor				LIMITS?		
Dermit Dermit		. Ib	10e. STREET AND NUMBER	10g. CITIZE	1 TYES 2 NO							
St.	1 5	LONEHAL	5220 York Road #	10		300	21212		.S.A.			
YLAND 21215-0020 by the hospital or attending physician. be detached for use as the burial-transit	20 20	- 11	11. MARITAL STATUS  1 Never Married 2 Married  3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR D	2 X NO	if yes, s	CENDENT OF NISPA specify Cuban, Maxic S 2 NO Speci	NIC ORIGIN? (Specify Yearn, Puarto Rican, etc.) fy:	n or No- 1	4. RACE — American Indian, Black, White, etc. Specify:		
15- tendin				16a DECEDENT'S	USUAL OCCUPAT	104	Tan min on an		white			
2121 al or atter for use a	once.		(Specify only highest grade completed) (Gi			work done during n se retired.)	nost of working	16b. KIND OF BU	SINESS/INDUS	STRY		
AND.	a 0		Elementary/Secondary (0-12)	I	S	ecretar	у	Board	of Ed	ucation		
the h	once.	5	17. FATNER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Sumame)			
MARYLAND retained by the hospit 5 should be detached	10		Hans Kerla					ne Sharling				
	notified TO D		19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	AOORESS (Street	and Number or Aural	Route Number, City or Tow	n, State, Zip C	ode)		
ay be	9	ŀ	20a, METNOD OF OISPOSITION	20	b. PLACE AND DATE	OF DISPOSITION /	Vame of	OATE 20c. LO	CATION CH	ty or Town, State		
OF m ector,	must		1 Donation 6 Other (Specify) 1	ovat from State CO	metery, crematory or o		tarrie or	200. 20	CATION - CR	y or lown, Stata		
BALTIMORE, hours after death. Page 6 may be din by the funeral director, page or removal.	in a		21. SIGNATURE OF FUNERAL SERVICE LK		Inda Dir	22. NAME /	AND AODRESS OF FA	CTO to	Anato	n 1		
AL death	examiner	ł	Immul ///L	Me Konatu w	aue, Dir	T .	J. Raltin	State nore, St.,E		my Board		
within 24 hours after spletely filled in by the cremation, or removal	medicai	1	23 PART I. Enter the diseases, or a shock or heart follows	complications that cause	d the death. Do	not enter the m	ode of dying, suc	th se cardiac or resp	iretory arres	it, Approximate		
24 hours at filled in by	E E		shock, or heart failure.  IMMEDIATE CAUSE (Final	Liat only one ceuse on e	each line.		-			Interval Between Onset and Death		
thin 24	event, the			SEVERE	ANOXI	C E	NCEPH	ALD PATI	HY			
				OUE TO (OR AS	A CONSEQUENCE O	F):				) - : : -		
68 and and o	traumatic		disease or condition resulting in death)  a. SEVERE ANONIC ENCEPHACO PATHY  OUE TO (OR AS A CONSEQUENCE OF):  CARDIO PULMOWARY ARREST  OUE TO (OR AS A CONSEQUENCE OF):  ANYS									
be be	ry, or other traumatic		CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Inj									
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ORDS, P. that the death of	any Injury,		PART II. Other algnificant condition	e contributing to deeth !	but not requiting	In the underlying	ng ceuse given in	Part i. 24s, WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS		
E # 0 %	any Inju		COLON CAR				WORK	1   YES 2	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
REC. requires	Shows		ARSCUSS	DIABETE					N _{no}	OF DEATN?		
L R law re as been bear, or	23 sh	.	DID TOBACCO USE CONTI	RIBUTE TO CAUSE C	OF DEATH YE	S   NO [	UNCERTAI	NX				
	1, or Item 23 HYSICIAN		25. WAS CASE REFERRED TO MEDICAL EXAMINER?	NOSPITAL:	26. PLACE OF OEAT	TH (Check only one OTHER:	)					
ICIAN:	اة إ		1 VES 2 NO 27. MANNER OF DEATH	1 Inpetient 2 - ER/Out		4 - Nursing Nor	me 5 - Raaidence					
O \( \frac{2}{2} \)	9 0		1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM INJ	URY	JURY AT ORK? YES 2 NO	28d. OEŞCRIBE HOW I	NJURY OCCU	RED		
ON ON Affer Affer death	11 0	- 8	Accident Investigation  3 Suicide & Could not be	28s. PLACE OF INJURY	/ — At home, farm, s			281. LOCATION (Street I	and Number or	Sural Soute Number		
DIVISION OF VITA OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate h hours after death with the State I	00 III	1	4 Nomicide 6 Could not be	building, atc. (Spe-	clfy)	,,		City or Town, State)	ind realizable of	rium riobte Number,		
O Se Pierri	COMPLET		29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of my know	riedge, death occum	ed at the time, dat	a and place, and due	to the cause(s) and mar	mer es stated			
THE HOSPITAL THE FUNERAL filed within 72	E NO									cause(a) and manner as stated.		
THE HO THE FUI fled with	-		29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI	MBER	29d. DATE 9	BIGNED (Month, Day, Year)		
2 2 2	TO B		D. Illopall	r.		MD	80	8238	D AT	nil 26,95		
	٦		30. NAME AND ADDRESS OF PERSON WHO				2	2 0	- 4			
		-	31. DATE FILEO (Month, Day, Year)			I HOSP	1700 0	STOTIMORE	7 14	D 21239		
			MAV 0 9 1005	32. REGISTRAR'S SIGN	2 A							



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3. TIME OF OEATH

more

10d. INSIDE CITY 1 YES 2 NO

14. RACE — American Indian, Black, White, atc. Specify: DIACK

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Pages 1, 2, 3 use as the burial-transit permit. attending physician. director, page 5 should be detached for the hospital à funeral the filled in by 6 cremation. completely bunial, and Hygiene nri 2 the atten Mental H signed by the t. of h has by Dept. OR ATTENDING PHYSICIAN: The certificate h the State this c

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FOR STATE REGISTRAR

GEDENT'S NAME, (First, Middle, Last)

AND THE OF CERTIFIES

2. DATE OF DEATH MONTH tine ane reem 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 19-26-5318 DAYS 1 - M 2 XF 1938 9a. FACILITY NAME (If not institution, give street end number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 6720 120 DIRECTOR Ownsbrook RESIDENCE OF DECEDENT 10e. STATE 10b. COUN 10c. CITY, TOWN OR LOGATION 10e. STREET AND NUMBER FUNERAL Town brook 101. ZIP CODE 109. CITIZEN OF WHAT COUNTAY? 6720 townsbrook 21207 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—if yee, specify Géban, Mexican, Puerto Ricen, etc.)

1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. AFMED FORCES? 1 YES 2 HO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 1 Never Married 2 Merried BY 3 Widowed 4 Divorced COMPLETED 15. OECEDENT'S EDUCATION ecity only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY dary (0-12) Hide 7. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maid Sr. Chambers ucille T 00 7amber a BE notified ORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City 2 Ave (41 380 more eamin 2 Da. METHOD OF DISPOSITION 200 DOCATION - City of Ton DATE SALG 20th PEACE AND DATE OF DISPOSITION (Name of must Ca Proposition of China ☐ Donation 5 ☐ Other (Specify) HAME AND ADDRESS OF FACILITY examiner 21. SIGNAT E OF FUNERAL SERVICE LICENSEE arch 300 me mosn Ja Na medical 23. PARTI Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. Liet only one cause on each line. IMMEDIATE CAUSE (Final the ARdioNASCU/ARDISONS disease or condition_ TORE US CAR OTIC DUE TO FOR AS A CONSEQUENCE OF): resulting in death) event, traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other OUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST -Injury, PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL any 1 YES 2 THO shows a PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) item EXAMINER 1 NO HOSPITAL: OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 5 Nesidence 8 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d. DEŞCRIBE HOW INJURY OCCURED marked, ( Detural) 1 YES 2 NO BY After 1 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 69 COMPLETED 8 Could not be determined DIRECTOR: / 4 Homicide 28 Hem 29a. CERTIFIER 1 ___CETJ#YING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner as stated, HOSPITAL FUNERAL within 72 h TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II EDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

PLETED CAUSE OF DEATH (TEM 27) (Type,

405

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

> town, no M Approximata Interval Betw Onset and Death 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 2 NO 29d. DATE SIGNED (Mgnth, Day, Year) 9 md DHMH-16 Rev 1/89

ST STEPPEN - WEE 211 0 2 1395 Mr. Rudon Ruce

10d. INSIDE CITY 1 YES 2XX NO

8:00 A 8. BIRTHPLACE (State or Foreign Country)

REG. NO.

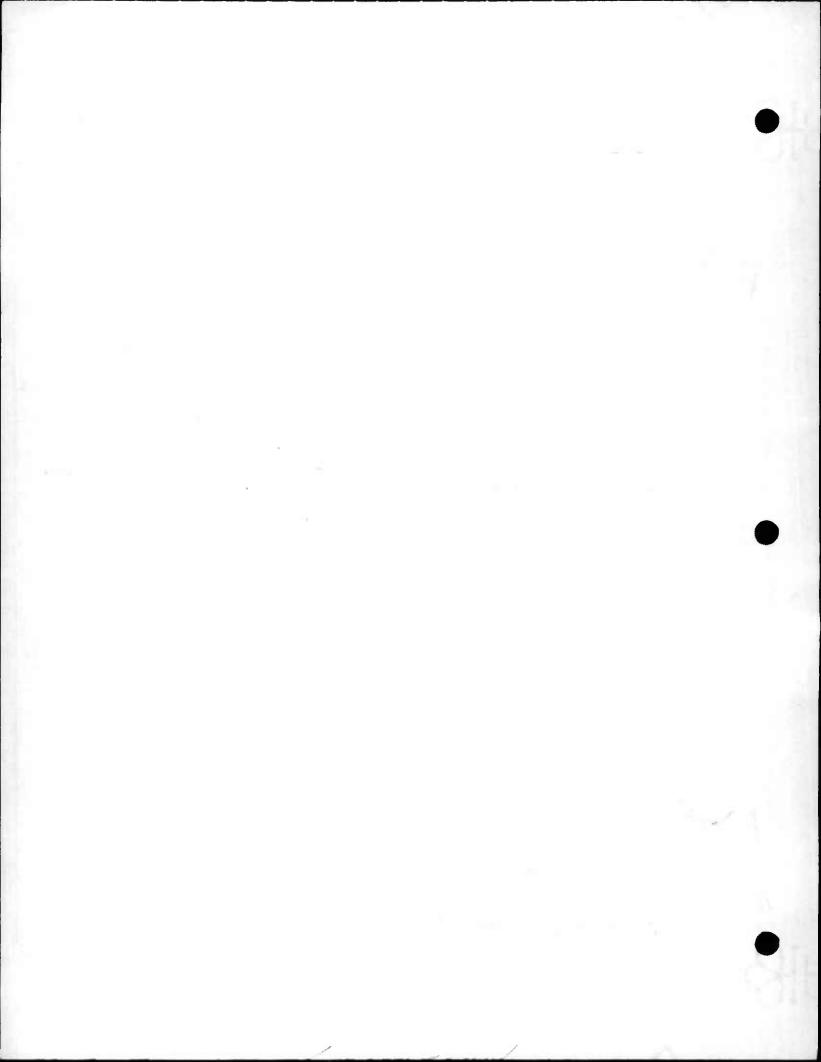
Approximate Interval Between **Onaet and Desth** 

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?

			To both DAY YEAR											3. TIME OF DEATH	
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			4. SOCIAL SECURITY NUMBER 213-68-7729	5. SEX	6. AGE (In yrs. Ia		IF UNDER 1 Y		UNDER 24 HRS.	7. DATE Of	Day Year)		Countr		
	Pi		9a. FACILITY NAME (If not institution, give :		39						21,1			vryland	
	2, 3 should	Œ	7523 Lawrence R	,	96. CITY, TOWN OR LOCATION OF DEATH  Dundalk				- J. J. J. J. J. J. J. J. J. J. J. J. J.						
	1, 2,	읝	7523 Lawrence Road Dundalk Baltimore										ore		
	Segr	DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION										10d. INSIDE CITY LIMITS?		
	£		Maryland	Baltimo,	re	Dundal									
	E E	FUNERAL	10e. STREET AND NUMBER					10f. ZIF	P COOE			10g. CIT	ZEN OF Y	VNAT COUNTRY?	
	an. ransit	剪	7523 Lawrence R						212	222		Ur	rited	d States	
20	ysici urlal-t	COMPLETED BY FU	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. A		13. WAS	S DECENO	DENT OF NISPAN	IC ORIGIN?	(Specify Yea	or No-	14. RACE Black	- American Indian, t, White, etc.	
5-0020	attending prysician. se as the burlal-transit permit. Pages 1,		3 Widowed 4 Divorced	IF YES, GIVE V						YES 21 NO Specify: Specify					
215	use as		15. DECEDENT'S EDU	CATION	16a. D	ECEDENT'S U	SUAL OCCL	JPATION		16b. K	"White				
<u> </u>	5 2		(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5	- 1/6	(Give kind of work done during m life. Do NOT use retired.)					16b. KIND OF BUSINESS/INDUSTRY				
9	osbura ched		12 Years			Dock	Work	er		F	reigh	it In	dust	ry	
A :	AYLAND 2 d by the hospital id be detached fo	흥	17. FATNER'S NAME (First, Middle, Last)						18. MOTNER'S NAME (First,						
MARYLAND retained by the hospit should be detached notified at once.	BE	Frank Geiger						Mary Mo							
	0	19a. INFORMANT'S NAME (Type/Print)		19				Number or Rural A							
	5 8 0		Sharon Geiger								Ck, Ma			21222	
JR.	ector, pa		20a METHOD OF DISPOSITION 1 Burlet 2 Cremation 3 Rem	oval from State	20b. PLACE cemetery, cr	AND DATE OF	DISPOSITION PLACE	ON (Name o	of .	OATE	20c. LO	CATION -	City or To	wn, State	
M	BALTIMORE, after death. Page 6 may be noval. cal examiner must be		4 □ Donation 5 □ Other (Specify)  21. SIGNATURE OF FINERAL SERVICE LII	TENGEE A	Sacre	a Ht c	Je Je	sus	Cem. 5/	1/95	Ba	timo	re,	MD	
<b>E</b> i	e funeral direction		J. SIGNATORE OF THERAC SERVICE EN				Du	da-R	luck Fun	ieral	Home	06 1	unda	lk. Inc.	
BA	e = e		21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  Duda-Ruck Funeral Home of Dundalk, Inc.  7922 Wise Ave. Dundalk, MD 21222												
			23. PART I. Enter the diseases, or shock, or heart failure	complications the	t caused the d	esth. Do no	t enter the	e mode	of dying, such	aa cardla	c or raspl	ratory ari	est,	Approximate	
			IMMEDIATE CAUSE (Final										Onset and D		
	reely fille mation, it, the		disease or condition a.										340		
68760	completely ial, cremati event, t	i	DUE TO (OR AS A CONTEQUENCE OF):										7		
89	sician and con nior to burial, traumatic en	S S													
č	or to	AT	If any, leading to immediate cause. Enter UNDERLYING												
<b>m</b>	e le p	윤	CAUSE (Disesse or Injury 6.												
0	attending phy tal Hygiene Y, or other	CERTIFICATION	that initiated events  resulting in death) LAST										İ		
S, P	y the atterd Mental			0.											
AD.	- 0	MEDICAL	PART II. Other significant condition	s contributing to	s contributing to death but not resulting in t				luse given in i	Part I. 2	4a. WAS AN . PERFOR		24b.	WERE AUTOPSY FINDS	
ECORD		ğ								_   1	TES 2	D NO		COMPLETION DF CAU DF DEATH?	
	been signe pt. of Healti		DID TODA GOO HEE GOATT					^-A						1 TES 2 NO	
1	has be Dept.	PHYSICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CA					UNCERTAIN	1 🗆 📗				•	
VISION OF VITAL	State (	S	EXAMINER?	HOSPITAL:			THER:								
FV	certificate the State	¥.	27. MANNER OF CEATN	1 Inpatient 2 28e, DATE OF		28b. TIME		c. INJURY	Realdenca (		Specify)	I II IBV OO	211050		
O	fer this sath with	<u>a</u>	Natural 5 Pending	(Month, D	Pay, Year)	INJUR	TY Y	WORK?	2   NO	280. DEŞÇI	HIBE NOW IF	IJUHT OC	COMED		
O	After death	6	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE C	OF INJURY — At h	ome, farm, stre				28f. LOCAT	ION (Street a	nd Number	or Aumi A	loute Number,	
S	JOR S	9	4 Homicide 8 Could not be determined	building,	atc. (Specify)					City or	Town, State)				
DIVISION	DIRECTOR	12	190. CERTIFIER (Check only	CIAN: To the heat of	emu kanauladaa d	anth annual	-A Ab 41	44							
_ ·	1 -10 -	N	(Check only one) 2 MEDICAL EXAMINE											and manner se state	
9	FUNERAL within 72	8	29b. SGRATURE AND TITLE OF CERTURE		7										
1	TO THE FUNERAL DE filed within 72 IMPORTANT: II	8	9. Pur tool	SII DE	nu.			29	C. LICENSE NUM	BER V	1	29d, DAT	SIGNED	(Month, Day, Year)	
	2 6 2 2	2	30. NAME AND ADDRESS OF PERSON WIN	O'COMPLETED CALL	SE OF OEATH (ITE	M 27) (Type P	rint)	1 /	01111	/		,	1 -01	///	
11	5		MILMARL BURL	er Jubi	ML	1940	Sui	ten.	(11/0	BAT.	of the	no D	7 / 7 1	M	
. (	/			F	1 -	·	-01		LUT Y	121-11	12014	1014	61 6	-	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

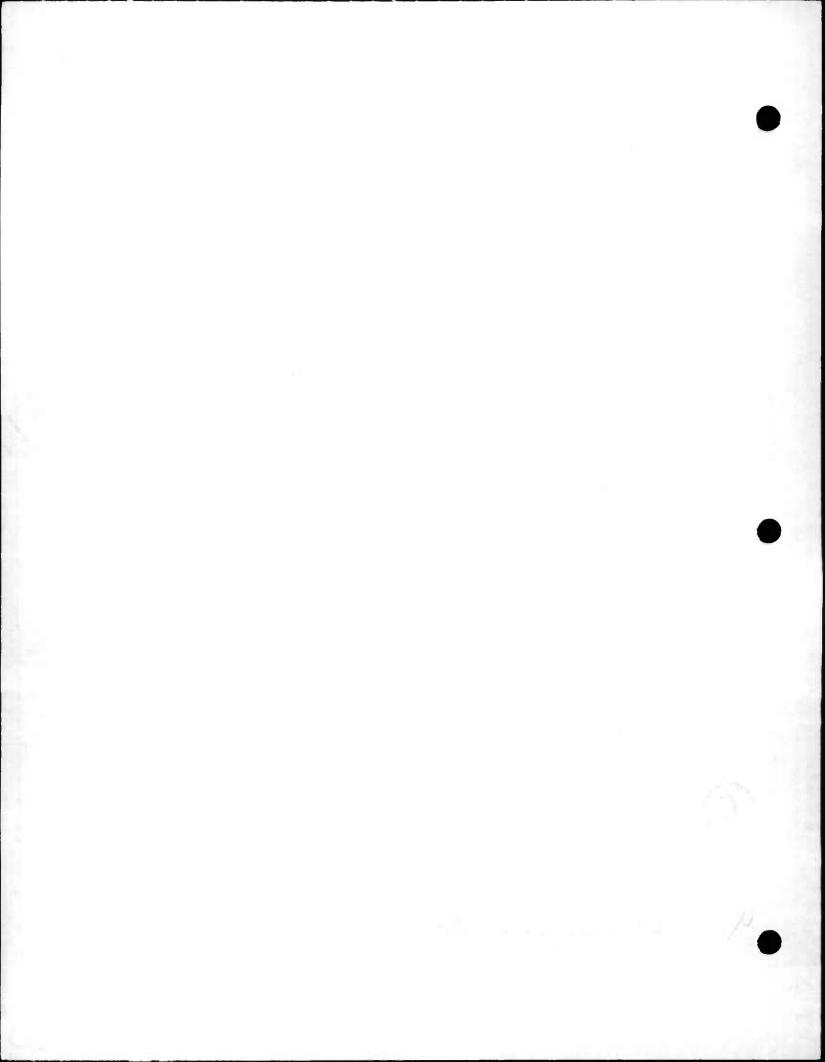
1 - FOR STATE REGISTRAR



		The same
if examiner must be notified at once.	IMPORTANT II nem 36 by marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	IMPORTANT II flerif &
val.	menth with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or remove	be filed within 72 hy atten
the funeral director, page 5 should be detached for	TO THE PURE DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to	TO THE FUNERAL DIRECTOR
er death. Page 6 may be retained by the hospital	ID THE MOSPITAL OR ITEMBING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital	TO THE HOSPITAL OR LITTLE

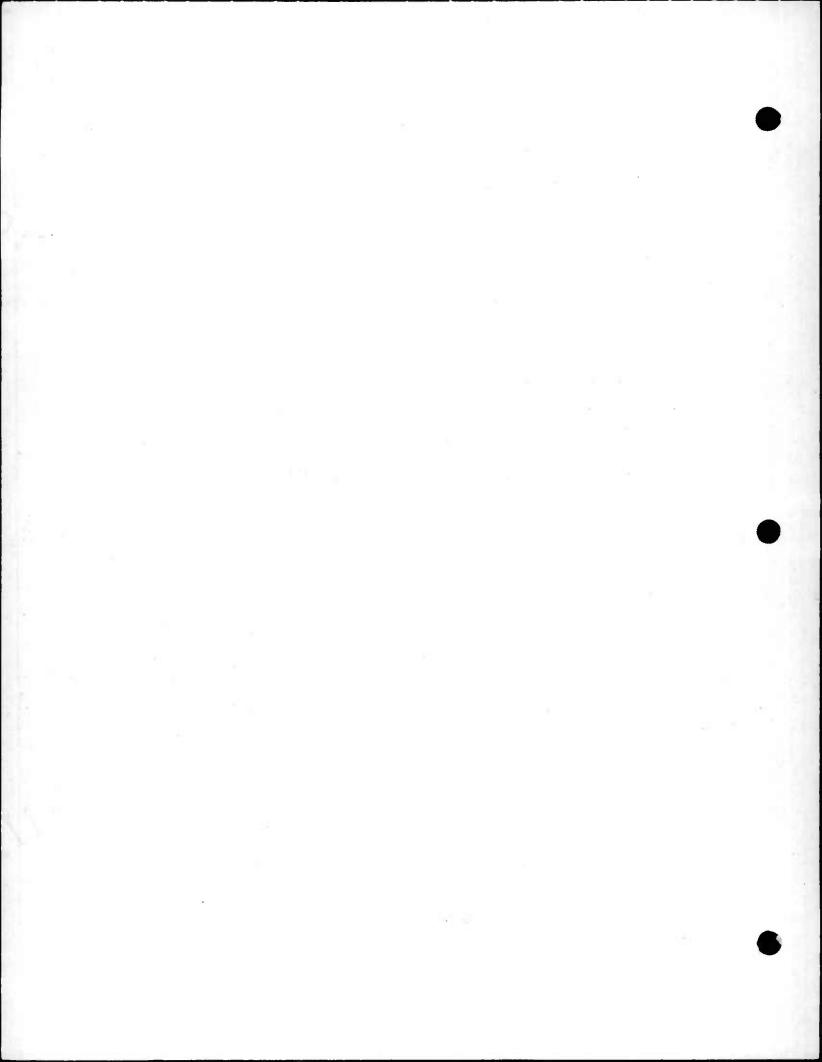
							90		3209	J	
	1 - FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPAR	TMENT OF I	HEALTH AND M	IENTAL HYGIEN REG. NO					
	1. DECEOENT'S NAME (First, Middle, Last)  JOSEPH HENRY G	GREENLOW				2. DATE OF DEATH APRIL 3	<b>Ö</b> 19	MEAD	TIME OF DEAT	н А "	
		5. SEX 6. AGE (1	in yrs. lest birthday)	77			7. DATE OF BIRTH 8. (Month, Day, Year)			reign	
		1 📆 M 2 🗆 F	79 YRS.	MONTHS DAYS	HOURS MIN.	August 24,	1915	Mary 1	Maryland		
œ	9e. FACILITY NAME (If not institution, give stree SACRED HEART HO			96. CITY, TOWN	OR LOCATION OF DEA	тн		Y OF DEATH			
6	RESIDENCE OF DECEDENT	JI IIAI		COMBER	LIMID		LLEGANY				
DIRECTOR	10e. STATE 10b. COUNTY			Y, TOWN OR LOCA				10-	d. INSIDE CITY LIMITS?		
	Maryland Allega 100. STREET AND NUMBER	any	Cu	mberland	f. ZIP COOE		100 CITE		YES 2 [	NO	
FUNERAL	1 Baltimore Street		21502			ted S					
F.	11. MARITAL STATUS  1 Never Merried 2 X Merried	2. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMEO	13. WAS DEC	ENDENT OF HISPANII	C ORIGIN? (Specify Yes			American India	m,	
B	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DA		1 TYES	2 X NO Specify:	, route racett, etc.)		Specify:	White		
<u>n</u>	15. DECEDENT'S EDUCAT (Specify only highest grade cor	TION (molester)	18e. DECEDENT'S	USUAL OCCUPATION	ON	16b. KIND OF BUS	SINESS/IND	JSTRY	MITTE		
COMPLETED	Elementery/Secondary (0-12)	College (1-4 or 5+)		work done during mo se retired.)							
OMP	12 17. FATHER'S NAME (First, Middle, Last)		Optica	l Lens G		Opti					
E C(	Henry Leo Greenlo	OW			4 (2011) 4 (1)	eth H.A.	,	٦٥			
TO B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street of		oute Number, City or Tow					
۲	Mrs. Mosselle L.	Greenlow	11	West Ma	in Street	Apt. 18	Frost	burg,	Md. 21	532	
	20e. METHOD OF DISPOSITION  1 M Burlel 2 Cremetion 3 Remove	of from State come	PLACE AND DATE (	ther placel		1		ity or Town,			
	4 Donatton S Other (Specify) Loudon Park Cemetery 5/2/95 Baltimore, Maryland  21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T 72 NOVEMBER 22. NAME AND ADDRESS OF FACILITY  22. NAME AND ADDRESS OF FACILITY										
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T. Zavoyna Leonard J. Ruck, Inc.										
	5305 Harford Road Baltimore, Md. 21214  23. PART I. Enter the diseases, or complications that caused the death, Do not enter the mode of duling such as cardiac or resolvency except.										
	IMMEDIATE CAUSE (Final										
										15	
_	DUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	Sequentially list conditions, If any, leeding to immediate  DUE TO (OR AS A CONSEQUENCE OF):										
S	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury										
TIF	CAUSE (Disease or Injury thet Initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST										
CE	resulting in deeth) LAST										
SAL	PART II. Other eignificent conditions of	contributing to death bu	nt not resulting i	n the Underlying	g cause given in Pa	art I. 24a. WAS AN PERFOR			RE AUTOPSY FIN		
EDIC	101944 349014014	in alley c	166/65	1001	11 cheir	1 U YES 2	2 NO		MPLETION OF CA DEATH?	AUSE	
Z	DID TOBACCO USE CONTRIB	BUTE TO CAUSE OF	DEATH YE	S D NO D	UNCERTAIN	TO TO		1 [	YES 2 N	0	
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL	2	a. PLACE OF DEAT	H (Check only one)	OTTOLKIAIIT			J			
YSI	1 - YES 2 NO 1	IOSPITAL:  Inipetient 2 - ER/Outpe	tient 3 🗆 DOA	OTHER: 4   Nursing Hom	e 5 🗆 Residence 8	Other (Specify)					
	27. MANNER OF DEATH  1 Natural 5 Pending	28e. OATE OF INJURY (Month, Day, Year)	28b. TIMI	URY WO	RK?	28d. DESCRIBE HOW II	NJURY OCCI	JRED			
B	2 Accident Investigation	28e. PLACE OF INJURY	- At home, farm, a		ES 2 NO	281. LOCATION (Street a	and Number of	e Rural Pouts	Alumbus		
A I	4 Homicide determined	building, etc. (Specif	(y)	,		City or Town, State)	TO THUMBUT C	THURST FIGURE	rumoer,		
1	29e. CERTIFIER (Check only	N: To the best of my knowle	dge, desth occurre	d at the time, date	end place, end due to	the ceuse(e) end men	ner ee state	ı.			
COM	one) 2 MEDICAL EXAMINER: 0								menner ee ate	sted.	
BE C	296. SIGNATURE AND TITLE OF CERTIFIER	101	.11		29c. LICENSE NUMB	ER	29d. DATE	SIGNED (Mo	nth, Day, Year)		
0	30. NAME AND ADDRESS OF PERSON WHO C	March	/ M	2/-4	MD 35	135	APR	130	195		
	Thanks of Person WHO C	10 Artill A		Z Sofon	Dr Pi	mbo-lan	1 111	17	507		
	31. DATE FILED (Month, Day, Year)	12 REGISTRAR'S SIGNA		- 1010N	V. C4	MACHIGAN	1 80%	3 20	3-		
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31. DATE FILED (Month, Dey, Year)
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DIVISION OF VITAL RECORDS, I	
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- NEC	BISTRAR			ICATE OF		MENTAL HYGIEN REG. NO.					
		liam Joseph C				2. DATE OF DEATH DATE APRIL 30		3. TIME OF DEATH 1:00 a M			
57	9-14-6283	1 X M 2 □ F 7	(In yrs. lest birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS, HOURS MIN,	7. DATE OF BIRTH (Month, Day, Year) Dec. 23	1920 Wa	RTHPLACE (State or Foreign untry) Shington. D.C			
E Lo	ITY NAME (If not institution, gh rien Nursing	& Rehab. Cen	iter		umbia	EATH	9c. county of oeath Howard				
Marv	Maryland  106. COUNTY Howard  106. STREET AND NUMBER			Y, TOWN OR LOCA	columbia		10d. INSIDE CITY LIMITS? 1  YES 2 YNO				
7080	O Cradlerock			10	1. ZIP CODE 2104	.5	F WHAT COUNTRY? SA				
0 g a a a a a a a a a a a a a a a a a a	11. MARITAL STATUS  1 Never Married 2 Married  3 Wildowed 4 Divorced  12. WAS DECEDENT EVER IN U.S. FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES. 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES? 1 FORCES. 1 FORCES FORCES? 1 FORCES? 1 FORCES FORCES. 1 FORCES FORCES FORCES FORCES. 1 FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES FORCES F			If yes, sp		NIC ORIGIN? (Specify Yea an, Puerto Ricen, atc.) fy:	B	ACE — American Indian, lack, White, alc. pacify: White			
5 5 E E E	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5 +)			USUAL OCCUPATION work done during more retired.)		166. KIND OF BUS					
	Peter J.	Griffin	Aviatio	J11	ľ	ME (First, Middle, Maiden erine Yoe		lient			
Hele	RMANT'S NAME (Type/Print)  On F. Griffi  HOD OF DISPOSITION		7080 (	Cradlero	ck Way,	Route Number, City or Town	mbia, M	D 21045			
D S S S S S S S S S S S S S S S S S S S	el 2 【XCremation 3 ☐ Restion 5 ☐ Other (Specify) _	moval from State	b.PLACE AND DATE metery, cremetery or o etro Crer McDonald	natory,	Inc. 05	/01/95 Ba	cation — city or 1 timore				
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within 24 within 24 within 24 cremation.	shock, or heart fellur ATE CAUSE (Finel or condition g in death)	e. List only one couse on a	consequence of	nce		h as cardiac or respi	ratory arrest,	Approximate Interval Between Onset and Death			
Tany, le	cially list conditions, sading to immediate Enter UNDERLYING (Disease or injury leted events to in death) LAST	c	A CONSEQUENCE OF								
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

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hours after death. Page	filled in by the funer on, or removal.	
HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direction of the funeral direction of the funeral direction of the funeral direction.	
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	ļ	t. DECEDENT'S NAME (First, Middle, Last)	M GAF							2. DATE OF DEATH MONTH	DAY	YEAR	3. TIME OF OEATH A
		4. SOCIAL SECURITY NUMBER		(In yrs. last	-	IF UNDER 1 YEAR IF UNDER 24 HR MONTHS DAYS HOURS MIN		Man	7. OATE OF BIRTH (Month, Day, Year)	1917		LACE (State or Foreign	
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m m		17. FATHER'S NAME (First, Middle, Last) PATRICK QU	JINN					MAR		NE (First, Middle, Maid	,	ILEY	
TO B		190. INFORMANT'S NAME (Type/Print) PATRICK GAFFNEY	(SON)	196	. MAILING 2306	ADDRESS WXDU	(Street ar			DON VIRG			
r must b		20a. METHOD OF DISPOSITION  1 Dir Burlei 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify)  20b. PLACE AND DATE Of DISPOSITION (Name of CALVARY CEMETERY 5-4-95 PITTS BURGH PENNSYLVANIA)  21. SIGNATURE OF FUNERAL Service LICENSEE  22. NAME AND ADDRESS OF FACILITY											
		VITZKE FUNERAL HOME OF CATONSVILLE 1630 EDMONDSON AVE. BALTO. MD. 21228  23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resource reset.											
ent, the medical		23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):  Approximata intervel Between Onset and Death  Approximata intervel Between Onset and Death  Approximata intervel Between Onset and Death  Approximata intervel Between Onset and Death  Approximata intervel Between Onset and Death  Approximata intervel Between Onset and Death  Approximata intervel Between Onset and Death  Approximata intervel Between Onset and Death  Approximata intervel Between Onset and Death  Approximata intervel Between Onset and Death  Approximata intervel Between Onset and Death  Approximata intervel Between Onset and Death  Approximata intervel Between Onset and Death  Approximata intervel Between Onset and Death  Approximata intervel Between Onset and Death  Approximata intervel Between Onset and Death  Approximata intervel Between Onset and Death  Approximata intervel Between Onset and Death  Approximata intervel Between Onset and Death  Approximata intervel Between Onset and Death  Approximate intervel Between Onset and Death  Approximate intervel Between Onset and Death  Approximate intervel Between Onset and Death  Approximate intervel Between Onset and Death  Approximate intervel Between Onset and Death  Approximate intervel Between Onset and Death  Approximate intervel Between Onset and Death  Approximate intervel Between Onset and Death  Approximate intervel Between Onset and Death  Approximate intervel Between Onset and Death  Approximate intervel Between Onset and Death  Approximate intervel Between Onset and Death  Approximate intervel Between Onset and Death  Approximate intervel Between Onset and Death  Approximate intervel Between Onset and Death  Approximate intervel Between Onset and Death  Approximate intervel Between Onset and Death  Approximate intervel Between Onset and Dea											
or other traumatic event, ERTIFICATION		Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING											
Y, or other		CAUSE (Disease or injury that initiated events Due to (OR AS A CONSEQUENCE OF):											
any Injur		PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED?  1 YES 2 NO COMPLETION OF CAUSE OF DEATH?											
23 sho		DID TOBACCO USE CONTRIL				-		UNCE	RTAIN				YES 2 NO
		EXAMINER?	HOSPITAL:			OTHER:		5 🗆 Res	Idence 6	□ Other (Specify)			
BY PHY		27. MANNER OF DEATH  t Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)		28b. TIMI	E OF :	28c. INJU WOF t Y			28d. DEŞCRIBE HOV	/ INJURY OCC	CURED	
28 IS		3 Suicida S Could not be datarmined	28a. PLACE OF INJURY building, atc. (Speci	— At hon	ne, farm, a	treet, factor	ry, office			28f. LOCATION (Stree City or Town, Sta	t and Number te)	or Rural Ro	ute Number,
O BE COMPLE			IAN: To the best of my knowlers: On the basis of exemination										and manner as stated.
D BE C		296. SIGNATURE AND SIZE OF CENTIFIER						29c. LICEN	SE NUME	_	29d, DAT	E SIGNED (1	Month, Day, Year)
2	I	30. NAME AND ADDRESS OF PERSON WHO				Print)	2		Do	00			2 44

the second of the second

1995

9c. COUNTY OF DEATH

U.S.A.

N/A

10g. CITIZEN OF WHAT COUNTRY?

3. TIME OF OEATH

10d. INSIDE CITY

14. RACE — American Indian, Black, White, atc.

Specify: White

LIMITS? Y

Approximate

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH?

1 TES 2 NO

interval Between

Onset and Death

8. BIRTHPLACE (State or Foreign

Wisconsin

2:45

PM

FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last, 2 DATE OF DEATH 1 Gust APRIL GILGASH 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH
(Month, Day, Year)
May 24, 1899 IF UNDER 1 YEAR IF UNDER 24 HRS. 1 X M 2 - F 188-05-9748 95 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF GEATH DIRECTOR St. Agnes Hospital Baltimore RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland **Baltimore** Catonsville permit. F 10- STREET AND NUMBER FUNERAL 10f. ZIP CODE 1212 Frederick Road 21228 page 5 should be detached for use as the burial-transit hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married FORCES? 1 YES 2 NO BY 3 Widowed 4 Divorced 18s. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor Carpentry notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) Arnold Philip Gilgash Kate Trierweiler BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Ethel I. Gilgash 1212 Frederick Road Catonsville, MD 21228 e 20 METHOD OF DISPOSITION
1 D Burlei 2 □ Cremation 3 □ Res 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Must n and completely filled in by the funeral director, to bunial, cremation, or removal, Mountain View Cemetery April 29, 1995 4 Donation 8 Other (Specify) Marriottsville, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Leroy M. & Russell C. Witzke Funeral Home 1630 Edmondson Ave Catonsville, MD 21228 70 event, the medical 23. PART I. Enter the diseases, or complications that the death. Do not enter the mode of dying, such as cardiac or reapiratory arreat, ahock, or heart failure. List only one caus **IMMEDIATE CAUSE (Final** disease or condition resulting in death) requires that the death certificate be executed within VISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF) DEHY PRAT traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) been signed by the attending physician a it. of Health and Mental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING ENOSCLEROTE CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in death) LAST 6 PART ii. Other aignificant conditions contributing to death but not reaulting in the underlying cause given in Part i. MEDICAL 24a, WAS AN AUTOPSY PERFORMED? эпу 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: WTENDING PHYSICIAN: The law has b 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h HOSPITAL: 1 TYES 2 NO OTHER Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 9 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED marked Natural 2 Accident 5 Pending 1 YES 2 NO Affer 1 BY 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town. State) 3 Sulcide .22 COMPLETED 8 Could not be 4 Homicide 28 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the basis of examin TO THE HEPPI TO THE FLAT TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE TO THE PLATE ation and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER

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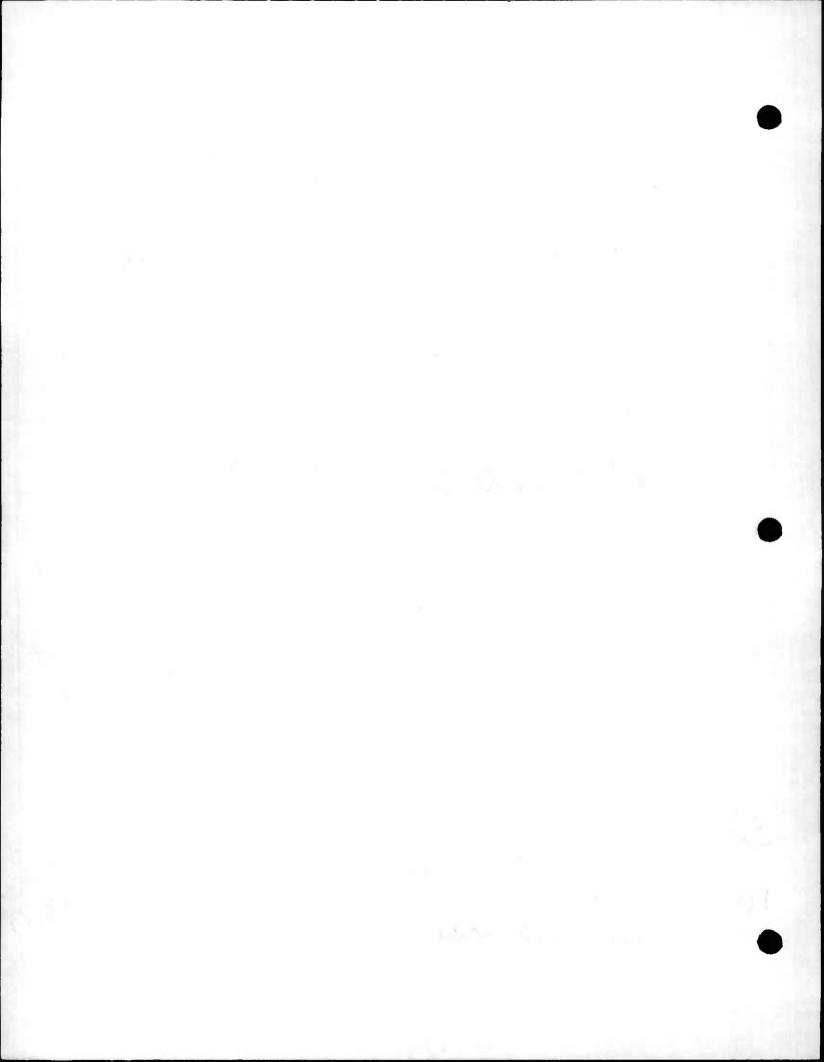
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

29d. DATE SIGNED (Month, Day,

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BSTOFN

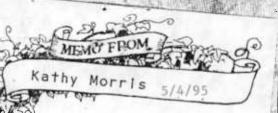


FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEOENT'S NAME (First, Middle, Leet) 2. DATE OF DEATH 3. TIME OF DEATH Isaiah German 7:30 April 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign 10-23-36 213-32-0552 1 XM 2 - F 58YRS Maryland Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 2600 Liberty 9c. COUNTY OF DEATH DIRECTOR Liberty Medical Center Heights Ave Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 18c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore by the funeral director, page 5 should be detached for use as the burial-transit permit, removal. 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3612 Eldorado Ave. #3A 21207 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—It yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Married 1 TYES 2 NO Specify: BY Specify: 3 Widowed 4 Divorced white COMPLETED 15. DECEOENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INOUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) once. 17. FATNER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) German, notified at Larry BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mary Boyd 2200 Homewood Ave., #105, Balto., MD 21218 Pe 20a. METHOD OF DISPOSITION must 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State 1 Buriel 2 Cremetton 3 Remote Contaction 5 Other (Specify) examiner IL SONATURE OF JUNERAL SERVICE LICENSEE ROTALD Wade, Dir. 22. NAME AND ADDRESS OF FACILITY 655 W. Balto. ST. State Anatomy Board, Balto., MD 21201 Tan medical 23/PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in and completely filled in by to burial, cremation, or remo Approximata shock, or heart failure. List only one cause on each line interval Bety **IMMEDIATE CAUSE (Final** Onset and Death the disease or condition resulting in death) Encephalopathy DUE TO (OR AS A CONSEQUENCE OF) OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 weeks event, oaqulopathy 2 weeks traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CO been signed by the attending physician at of Health and Mental Hygiene prior to if any, leading to immediate Bleeding Gastrointestinal cause. Enter UNDERLYING 2 weeks CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 10 Injury. PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a, WAS AN AUTOPE'S Insufficiency PERFORMED hronic Rena shows any 1 TYES 2 NO OF DEATH? 1 TES 2 NO has be Dept. c 23 sh DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL: certificate h Item OTHER: 1 YES 2 NO npatient 2 - ER/Outpatie HT 3 DOA 4 Nursing Nome 5 Residence 8 Other (Specify) 6 the 27. MANNER OF GEATH 28e. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, this c 1 Natural 5 Pending Investigation 1 YES 2 NO BY After 1 2 Accident DIRECTOR; Aft hours after de-item 28 is n 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide ETED. 28t. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be 4 Nomicide hours a Item 2 29e. CERTIFIER CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. COMPL TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 THE IMPORTANT: If It (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 41365 April 26, 1995 RESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2 George E. 31. DATE FILED Month, Day. 32. REGISTRAR'S SIGNATURE MAY 1 2 1995 Randall

DHMH-18 Rev 1/89

, 26, 1995 Ave

		1 - STATE REGISTRAR	STATE OF MARYLA	AND / DEPAR CERTIFI	TMENT OF H	HEALTH AND	MENTAL	HYGIENE REG. NO.				
	1	1. OECEDENT'S NAME (First, Middle, Last)	Margaret /	ACK.	Hackett		2. DATE O MONTH	F DEATH DAY Z 7	9 SEAB	3. TIME OF GEATH 3. 340 M		
should	1	4. SOCIAL SECURITY NUMBER 215~03~8801  9a. FACILITY NAME (If not institution, give s	1 M 2 Q F 77	in yrs. lest birthday) YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Dec.	14,1917	Mari	yland		
1, 2, 3	CTOR	Johns Hopkins Bo		l Ctr.		nore City			V/A			
permit. Pages	L DIRECTOR		v timore	10c. CITY	, TOWN OR LOCAT	Dunc	dalk			10d, INSIDE CITY LIMITS? 1 YES 2 NO		
. sit	LETED BY FUNERAL	100. STREET AND NUMBER 1006 OLd North 1					1224	u	rited	States		
21215-0020 al or attending physician, for use as the burial-transit		1 Never Married 2 Married  3 XXWidowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, OIVE WAR OR DA	2 X NO	If yes, sp	CENOENT OF HISPAR ecify Cuben, Maxica 5 2 💢 NO Specify	ın, Puarlo Ric	(Specify Yes or No— sen, etc.)	14. RACE Black, Specify	— American Indian, White, atc. " White		
2121 al or atto for use		15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	ork done during mo e retired.)	ost of working	16b. K	IND OF BUSINESS/IN				
MARYLAND : retained by the hospital 5 should be detached it	COMPL	17. FATHER'S NAME (First, Middle, Last)	2 Years	seco	Employe		ME (First, Mic	Real Extended Surname)	state			
क दिन्	BE C	Samuel Berto 190. INFORMANT'S NAME (Type/Print)	_	I Table 2 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and 100 and		Anna F	Rossi					
8 8 6 m	5	E. Virgil Hack		2906	Parksio	te Lane t	larris	burg, PA	1711			
MOR e 6 may rector, p		1)() Suriel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	noval from State	PLACE AND DATEO	Cemeteri	5/1/19	1 -	Balt	imore,	Maryland		
SALT r death. e funera al. examil		Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222										
EOX 68760  ficate be executed within—x, hours after the physician and completely filled in by the prior to bunal, cremation, or removing transmitting the medical ner traumatic event, the medical ner traumatic event, the medical control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or control or con	FICATION	23. PART I. Emer the diseases, or a suck, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	a. /n'tra Ce	consequence of	He			Infarc		Approximate interval Between Onset and Death 60min 17hrs		
the death certify the attending of Mental Hygie	CERTI	resulting in death) LAST	d									
RECOR requires that been signed b of Health an	: MEDICAL	PREFORMEO? AMAILABLE PRIOR COMPLETION DE 10 OF OEATH?  1 YES 2 NO COMPLETION DE 10 OF OEATH?  1 VES 2								WERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH?    YES 2   NO		
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CLAN Certific Line	HYS	27. MANNER OF DEATH	1 Supotient 2 ER/Outpe 28s. DATE OF INJURY	28b. TIME	4 Nursing Hom OF 28c, INJ			ipecity) IIBE HOW INJURY O	CURED			
TENDING PHYS OR: After this of frer death with	B	Natural 5 Pending Investigation 3 Suicide 6 Could not be	(Month, Day, New) 28s. PLACE OF BUJURY	MUSC.	W 1 1	PES 2 NO	-11-500	Altonomicano.				
DIVISION OR ATTENDING DIRECTOR: After hours after death item 28 is ma	ETED	4 Homicide determined	building, etc. (Specif	fy)	reac, including, distance		City ar	ON (Street and Numbe lown, State)	r or Hurst No	oth Mumber;		
F 2F F	COMPLETED	(Check only	Claff: To the best of my knowle of On the bests of diamination							and manner as stated.		
TO THE HOSPIT TO THE FUNERA De filed within 7	8	286. SIGNATURE THO TITLE OF CENTURE	Saucen	nD		29c. LICENSE NUN 950	13	29d. DA	E SIGNED (	Month, Day, Year)		
7	2	HOWARD	DOMPLETER GARDE OF DEA	VACT		H	940	Facter	n Br	e JOHBM		
		MAY 0.9 1995	Jahr Budsonk	wolf						1		

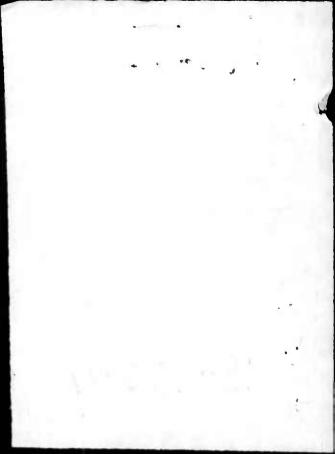


DO NOT ISSUE COPIES
ON THIS RECORD!
SEE KATHY MORRIS!
or Randy Brooks First

Do Not issue copies to
Ralph Rothwell, Atty.
Phone# for Son/Daughter
(707)447-7468

95-13214

all du VIII h . se.



L. Rothwell storney, do not issue on ald will 1990 July 1993 Codici Son daugster new will (707) 447-7468 en all wall 1990

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DIVISION OF VITAL RECORDS, P.O. BOX 13146,	AVA
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	BETALL THE KITTENDING DEVOLUTAN. The law requires that the death certificate he executed within

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 6:35 Am ernon arres 30 04 7. OATE OF BIRTH (Month, Day, Year 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 13-03-7318 1 M 2 | F 84 YRS. Maryland 9e. FACILITY NAME (If not institution, give 9c. COUNTY OF DEATH Baltimore DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 18c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Baltimore Essex 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 919 Lutz Ave. 21221 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 If yes, specify Cuban, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 25 Married Specify: B 3 Widowed 4 Divorced White ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highes ng most of working (Give kind of work done life. Do NOT use retired.) Elementery/Secondary (0-12) College (1-4 or 5+) COMPL Supervisor Lever Bros. 12th 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) aţ John BE Harrer Bertha Goetainaer notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Stephanie Harrer Lutz Ave. Baltimore MD must be 20e. METHOD OF DISPOSITION
1 🖫 Burisi 2 □ Cremetion 3 □ Removal from State 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) 20c. LOCATION - City or Town, State 0ak LAwn Cemetery 5/2/95 4 Donetion 5 Other (Specify) Baltimore MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home of Essex ons that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, medical 23. PART I. Enter the diseases, or complication only one cause on each lie ehock, or heert in Interval Between **Onset end Death** IMMEDIATE CAUSE (Fine) the arrhys disease pr condition Cardiac one how traumatic event, resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF): 1-2 NOUY 2 CERTIFICATION Sequentielly list conditions. DUE TO (OR AS A CONSEQUENCE OF): Many If eny, leeding to immediate years ten Dine ceuse. Enter UNDERLYING CAUSE (Diseese pr injury or other TO (OR AS A CONSEQUENCE OF): that initiated events reculting in deeth) LAST injury, PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE item 23 shows any 1 TYES 2 THO OF DEATH? 2 1 TYES 2 NO ovas Cular (3) Cardy recont PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: 1 D YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ne 5 🗆 Residence 6 🗆 Other (Specify) 9 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 27. MANNER OF DEATH 28c. INJURY AT WORK? 26d, DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending Investige 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 261. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 69 COMPLETED 6 Could not be Item 28 is 4 Homicide determined ECERTIFIER

(Charles and 1) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) end mannar ee stated. = 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER 754 29d. DATE SIGNED (Month, Day, Year) TO THE R TO THE R De filed w BE -MD 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (TYPO, PHIN)

MALIKA WASBEM, MD, 100. N. BROADWAY, BALTIMORE, MD-21231. 22. REGISTRAR'S SIGNATURE

BALTIMORE, MARYLAND 21215-002

TO THE HOSPTAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

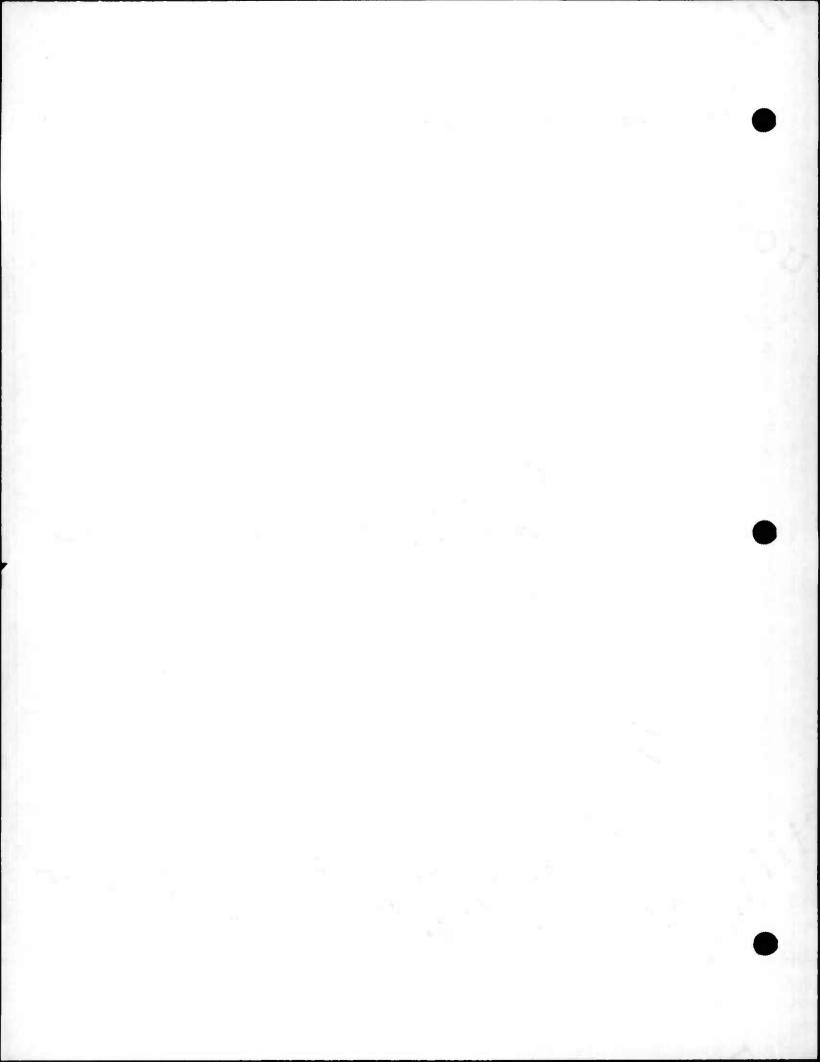
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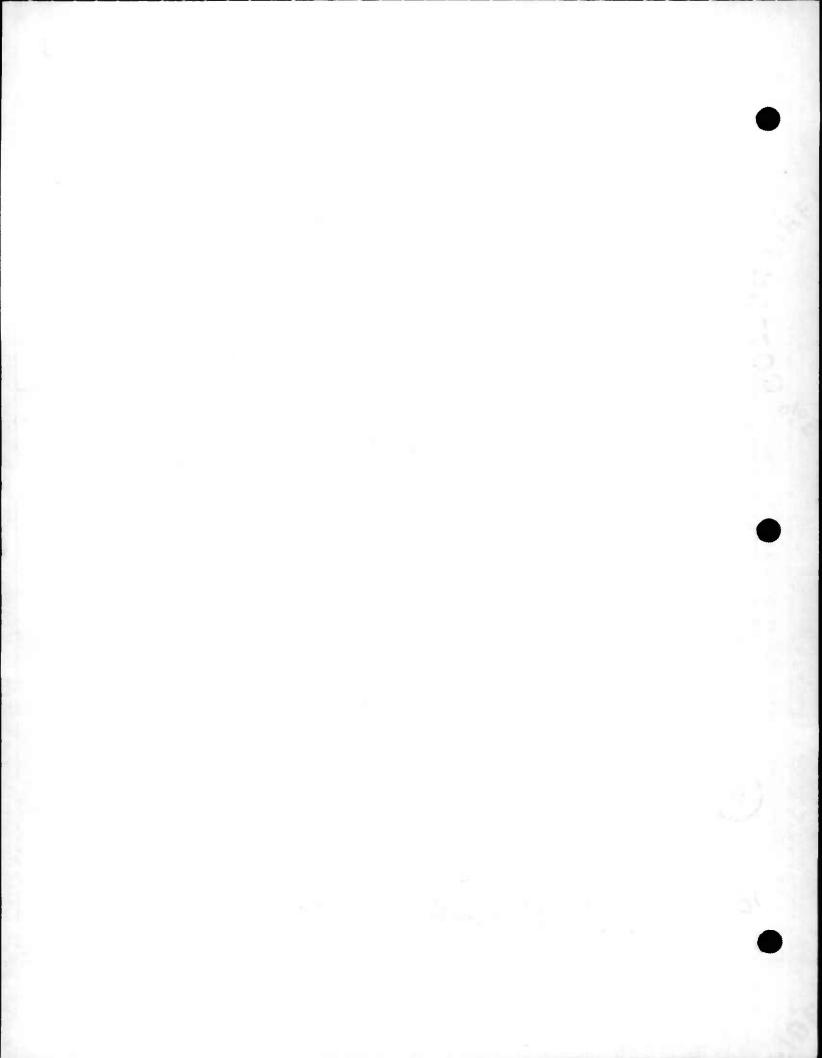
	1 · STATE REGISTRAR	STATE OF M	ARYLAND / CE	DEPAF RTIF	TMENT ICATE	OF H	EALTH DEAT	AND N		HYGIENI REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Land)	R	Hum	4 4					2. DATE OF MONTH	DEATH	Y 6	YEAR	3. TIME OF DEATH 940A M	
15	4. SOCIAL SECURITY NUMBER 219-64-2984	5. SEX 1 🔀 M 2 🗌 F	6. AGE (In yrs. last	birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF NOV. 2	BIRTH		Country	''	
OR	9e. FACILITY NAME (If not institution, give LAUREL REGIONAL HOSE				9b. CITY	, TOWN C	R LOCATIO	ON OF DE			9c. COU	MARYI NTY OF DI RINCE		
DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNT	TY		10c. CIT	Y, TOWN C	B LOCAT	ION						tod moles out	
	MARYLAND	PRINCE GEORG	GE		.,		LAURE	L					10d. INSIDE CITY LIMITS7 1 YES 2 NO	
ERAL	13129 LARCHDALE ROAD	) APT #7			101. ZIP CODE 20708							Dg. CITIZEN OF WHAT COUNTRY?  USA		
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2XX Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [ IF YES, GIVE WA	YES 2 NO		1 1	f yes, spe	ENDENT O	ı, Mexican	IC ORIGIN? (S , Puerlo Rica	Specify Yea in, atc.)	or No—	14. RACE Black Specif	— American Indian, , White, etc.	
COMPLETE	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12)	(Give	o kind of u	se meineci)	during mos	emp1		16b. KJ	NO OF BUS	INESS/IND				
BE COM	17. FATHER'S NAME (First, Middle, Last) ROBERT HUMPHREY	Ø		LAND	SCAFER		18. MOTH	ER'S NAN	AE (First, Mide ENNEDY			-		
TO B	190. INFORMANT'S NAME (Type/Print) MARY D. HUMPHREY	3			ADDRESS				oute Number,				20708	
	20s. METHOD OF DISPOSITION 1 ☐ Burlel 2√□, Cremation 3 ☐ Rer 4 ☐ Donetion	noval from State	20b. PLACE AN cemetery, crem BALT I MOT	atory or o	ther place)			npv	DATE		ATION —		1,3000	
	21. SIGNATURE OF FUNDAME SERVICE (	Si Coac	a.		22. (	7601	SANDY	S OF FAC	ING ROA	CK FUN D, LAU	ERAL	HOME, MARYL	INC. AND 20707	
	23. PART I. Enter the disease or shock, or heart failure iMMEDIATE CAUSE (Finel disease or condition resulting in death)	T Clar only one day	on each line	\			sec.		aa cardiad	or reapin	atory arm	eat,	Approximate Interval Between Onset and Death	
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	c	DR AS A CONSEQU	IENCE OF	F):	um	mi	9					Days	
		d												
DICAL	PART II. Other significant condition	a contributing to d		aulting i	in tha un	dariying	ceuse g	iven in F		B. WAS AN A PERFORM	AED?		WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
AN: MED	DID TOBACCO USE CONT	RIBUTE TO CAU					UNC	RTAIN					1 YES 3 NO	
SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL:	26. PLACE		OTHER	t:	5	uldana. 0	Other (S)					
BY PHYSICIAN:	27. MANNER OF DEATH  1 Netural 5 Pending 2 Accident Investigation	26s. DATE OF IN (Month, Day)	NJURY	28b. TIM		28c. INJL WOR	IRY AT		28d. DESCRI		JURY OCC	URED		
	3 Suicide a Could not be 4 Homicide determined	28e. PLACE OF building, et	INJURY — At home ic. (Specify)	e, ferm, a	treet, facto	ory, office			281. LOCATIO	ON (Street an own, State)	d Number	or Runal Ro	oute Number,	
COMPLETED	29a. CERTIFIER CCERTIFYING PHYSIONE) 2 MEDICAL EXAMIN												and manner as stated.	
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIE	m 562	)				29c. LICE	2-8	992	8	D 4	420		
Ĺ	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE	OF DEATH (ITEM	27) (Type,	Print)	LM	#	2-1	r C	au	rel	m;	D 20708	
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			rthuy i	Harrin			2. BATE OF DEATH	DAY VE	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER 061-32-5261	5. SEX 6. AGE	(In yrs. last birthday) 54 YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	MAY 31, 19		BIRTNPLACE (State or Foreign Country) EW YORK
3 should	Œ	9a. FACILITY NAME (If not institution, give 16009 KENT ROAD	street and number)	-	96. CITY, TOWN	OR LOCATION OF D		9c. COUNTY	OF OEATN
1, 2,	010	RESIDENCE OF DECEDENT			Laure			PRI	NCE GEORGE
Pages	DIRECTOR	MARYLAND P		10c. CIT	Y, TOWN OR LOC				10d. INSIDE CITY LIMITS?
ermit.		10e. STREET AND NUMBER	RINCE GEORGE		LAURE	Of, ZIP CODE		10g. CITIZEN	1 YES 2 NO
n. ansit p	FUNERAL	16009 KENT ROAD				20707			USA
ing physician. the burial-transit permit. Pages 1, 2,	BY FUN	11. MARITAL STATUS  1 Never Married 2 Married  3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 _ YES IF YES, GIVE WAR OR D	2 X NO	If yes, I	ECENDENT OF NISPAI specify Cuban, Mexica S 2 NO Specific	NIC ORIGIN? (Specify Wan, Puerto Rican, etc.)  y:	14.	RACE — American Indian, Black, Whita, atc. Specify: WHITE
or attending for use as the	ETED.	15. DECEDENT'S ED (Specify only highest grace Elementary/Secondary (0-12)		16a. DECEOENT'S (Give kind of life. Do NOT us	work done during n	TION nost of working	16b. KIND OF BI	USINESS/INDUST	RY
the hospital o detached for once.	COMPLET	12	Ø	PRODUC	TION MANA	GER	PF	RINTING	
	1 - 1	17. FATHER'S NAME (First, Middle, Last)  JOHN D. HARRINGTON				18. MOTHER'S NA HELEN HANG	ME (First, Middle, Maide	n Sumame)	
be retained by ge 5 should be e notified at	) BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street		Route Number, City or To	wn, State, Zip Cox	(e)
y be reti page 5 s	5	HELEN V. HARRINGTON					, MARYLAND		
e 6 may ector, pa must b		20a. METHOD OF DISPOSITION  1 X Burlal 2 Cremation 3 Rai  4 Donation 5 Other (Specify)		PLACE AND DATE OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY		Name of		OCATION — City	
Page al direc		21. SIGNATURE OF FUNERAL SERVICE L		LINCOLN		ANO ADDRESS OF FA			MARYLAND OME, INC.
hours after death. Page 6 may be ed in by the funeral director, page or removal. medical examiner must be		1 alae	Dulage	a,	7601	SANDY SPRIM	NG ROAD, LAUI	REL, MARY	LAND 20707
tely fill nation,		23. PART (. Enter the disease, or abook, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death)	Dia beter an	act line.	notes (		s and of		Onset and Death
ertificate be execute ing physician and co giene prior to buria other traumatic	ERTIFICATION	Sequentially list conditions, if any, leeding to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	c	A CONSEQUENCE OF					
the death of the attend   Mental Hy njury, or	O		d						
ires that the deat signed by the atte lealth and Mental ws any Injury,	MEDICAL	PART II. Other algnificant condition	ne contributing to death b	ut not resulting	in the underlyi	ng cause given in		RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATN?
w requires the been signed pt. of Health 3 shows and		DID TOBACCO USE CON	TRIBUTE TO CAUSE O	F DEATH YE	S INO I	UNCERTAIL			1 TYES 2 NO
N: The law ficate has bo State Dept.	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE OF OEAT					
certificate the State or Her	IYSI	1 VES 2 NO	1   Inpatiant 2   ER/Outp		OTHER:		8 Other (Specify)		
DING PHYS After this o death with	ву Рну	1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)		M 1	JURY AT YORK? YES 2 NO	28d. DEŞCRIBE NOW	INJURY OCCURE	0
L OR ATTENDING R DIRECTOR: After hours after death	ETED	3 Suicide 8 Could not be 4 Homicide detarmined	28a. PLACE OF INJURY building, atc. (Spec	— At home, farm, solfy)	street, factory, offi	ce	281. LOCATION (Street City or Town, State	and Number or R	ural Route Number,
4 3 2 E	COMPL	one) 2 MEDICAL EXAMIN	SICIAN: To the best of my knowl						use(a) and manner as stated.
TO THE HOSPIT TO THE FUNERA De filed within 7	O BE	296. SIGNATURE AND TITLE OF CERTIFIE	odujue,	mo		JOC. LICENSE NUM	ABER	DAY DATE SIG	NED (Month, Day, Year)
5		Augusto P. Rod	NO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Print) Day Dur	nCt.C	o. Snr. Yi	20 20	748
		MAY 0 2 1995	32 REGISTRAR'S SIGNA	LE	/		0		



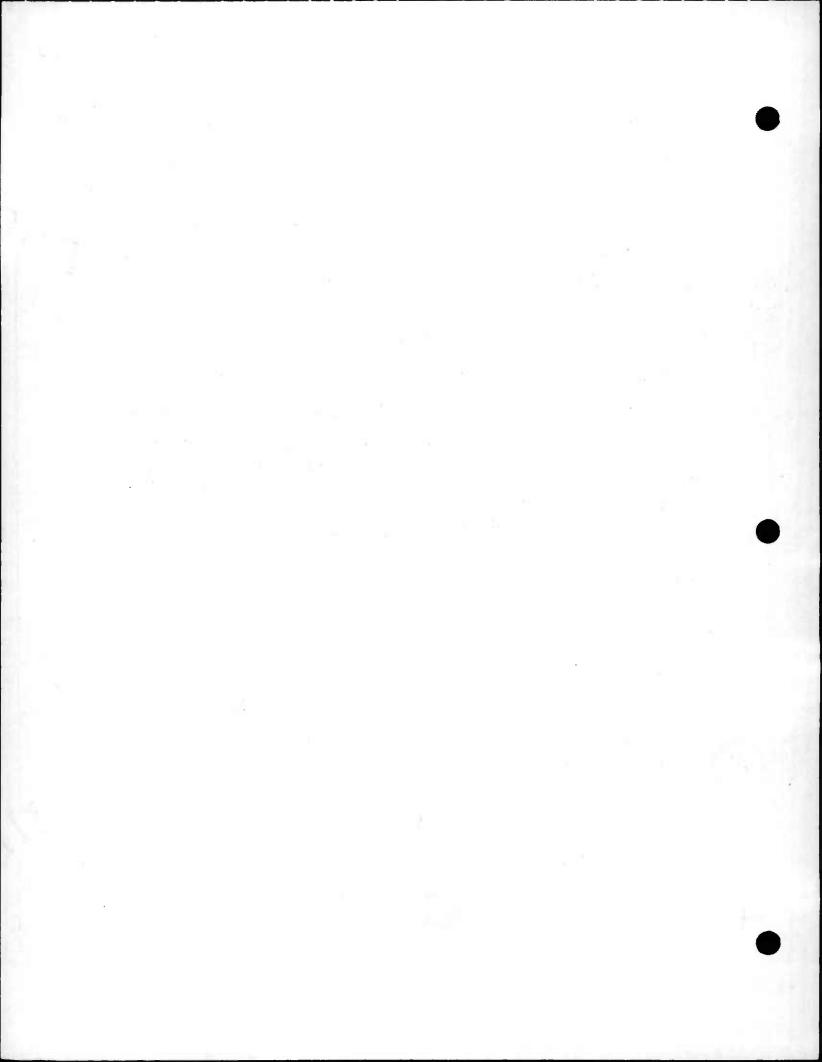
		1 -	FOR STATE REGISTRAR		STATE OF M	MARYLAND C	/ DEPAI	RTMENT	T OF H	DEAT	AND N		HYGIENI REG. NO.	E			
		1. D	ECEDENT'S NAME (Firs	st, Middle, Last)								2. DATE OF	DEATN			3. TIME OF DEATN	-
		Н	ERBERT					HES	EKI	EL		APR	TT. 2	v 8. 1	995	10:04 A	M
		- 10	001AL SECURITY NUM 7-24-9835		5. SEX	6. AGE (In yrs. II		IF UNDER	DAYS	IF UNDER	24 HRS.	7. DATE OF (Month, D				PLACE (State or Foreign	
pinc			FACILITY NAME (If not				YRS.						19,	1929		GERMANY	_
2, 3 should	CTOR	N .	712 BREN							LLST					TT T N		
	ם	RE 10a.	SIDENCE OF DE	10b, COUNT			10c. Cl	ry, town (			COWIN			DAL	TIM	10d. INSIDE CITY	_
permit. Pages	DIRE	MA	RYLAND	BALTI	MORE			NDAL								LIMITS?	
isi.	FUNERAL		STREET AND NUMBER 712 BRENTE			-			101	Z113	3			10 USA	ZEN OF W	HAT COUNTRY?	_
215-0020 attending physician.	B	11	MARITAL STATUS Never Married 2 [X Wildowed 4 Div		12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	T EVER IN U.S. A TYPES 2 MAR OR DATES WWII	RMED NO		If yes, sp	ENDENT O ecify Cubs 2 X NO	n, Mexicar	IIC ORIGIN? (5 n, Puerto Rice 7	Specify Yes in, stc.)	or No-	14. RACE Black Specifi	- American Indian, White, atc.	_
			15, DE	CEDENT'S EDU	CATION completed)	(	ECEDENT'S	work done	CCUPATIO	ON ast of workin	o a	16b. KI	ND OF BUS	INESS/IND	USTRY		_
S = D	once.		Elementary/Secondary (	(0-12)	College (1-4 or 5 e	·) #	ROPRI	ise retired.)		or or provide	•	PA	AWN SI	HOP			
2 8 8	7	17. F	ATHER'S NAME (First, I SIGMUND	Middle, Leat)		HES	EKIEL	,			IER'S NAI RNA	ME (First, Midd	lle, Maiden S		ENSCH	ÆL	
MAR retained 5 should	TO BE		INFORMANT'S NAME (		יעד בינ	1	96. MAILIN	ADDRESS	S (Street a	nd Number	or Rural R	loute Number,	City or Town	, State, Zip			_
	2					20b. PLACE	3712				. R	ANDALI				1133	
FORE e 6 may ector, pa	must		METHOD OF DISPOSI* Burlel 2 Cremeti Donation 6 Othe		oval from State	cemetery, ci	ematory or	other place)			4	/30/9!		STERS		vn, State N, MD	
TIM h. Page eral dire	ехатіпет	21. 5	IGNATURE OF FUNER	AL SERVICE LE	CENSEE	1		22.	NAME AN	ID ADDRES	SS OF FAC		-				_
BALTIMORE, after death. Page 6 may be by the funeral director, page			kus	alla	w X o	w		60	10 R	EIST	ERTO	WN RD	. BA	LTO.		21215	
within 24 hours pletely filled in t	ent, the	iMi	PART . Enter the c shock or I MEDIATE CAUSE (Fi sase or condition uiting in death)	neert fallure.	a. Happed	t caused that dise on each lin	e. 2 a					as cardiac				Approximate Interval Between Onset and Deat	
executand and and burn		if a	puantially list condi	diata	b. DUE TO	(OR AS A CONSE	OUENCE C								aris	- 18°	_
. 2 42	r other traumatic	CAI	se. Enter UNDERLY JSE (Disease Dr Inj t initiated eventa ulting in death) LAS	ury	cDUE TO	(OR AS A CONSE	OUENCE O	F):									
eath atten	91 111			-	d												-
RD at the by the and M	hows any injury, MEDICAL CE	PAF	T II. Other algnific	ant condition	a contributing to	death but not	resulting	in the un	nderlying	cause g	iven in i		PERFORM	WED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	5
w requires the been signed pt. of Health	shows ar	1 5	ID TOBACCO L	ISE CONT	DIRLITE TO CA	LISE OF DE	ATLI V	cc 10/1 i	NO F	1 UNC	ERTAIN	'	•			1 YES 2 NO	
AL AL	2 8	25. V	AS CASE REFERRED		KIBOTE TO CA		CE OF DEA			I UNC	EKIAIN	111					_
F VITAL SICIAN: The lan certificate has the State Dep	or item YSICI	100	EXAMINER? KIXYES 2   NO		HOSPITAL: 1   Inpatient 2	ER/Outpatient	3 🗆 DOA	OTHER 4 Num		• XXRe	sidence 1	8 Other (S)	pecify)				
O축하	BY PHY	1,	ANNER OF DEATH  Netural 5  Accident	Pending Investigation	28e. DATE OF (Month, Da		26b. TIR	IE OF JURY M		URY AT RK? 'ES 2	NO	28d. DESCRI	BE HOW IN	JURY OCC	URED		
DIVISION	ETED 8	3	Culatela -	Could not be determined	28s. PLACE Of building,	F INJURY — At h etc. (Specify)	ome, farm,	street, fact	ory, office			261. LOCATIO	ON (Street ar own, State)	nd Number	or Rural Ro	oute Number,	_
7 40	<b>=</b> 1 =				CIAN: To the best of R: On the baels of as											and manner as stated.	
TO THE HOSPITA TO THE FUNERA De filed within 7	PORTA BE C	29b.	SIGNAPURE AND WITE	OF CENTERES							NSE NUM			29d. DATE	SIGNED	(Month, Day, Year)	_
5 5 5	10 E	30.	AME AME ADDRESS O	PERSON WH	O COMPLETED CAUS	SE OF DEATH (ITI	M 27) (Type	, Print)		0.	C.M.	.E.		APR:	IL 2	9, 1995	_
16			Am	DW-	M.	0 111			tree	et,	Bal	timor	e, M	lary.	land	21201	
			MAY 0219	95 8	Li William	er grantska.He								7.412			



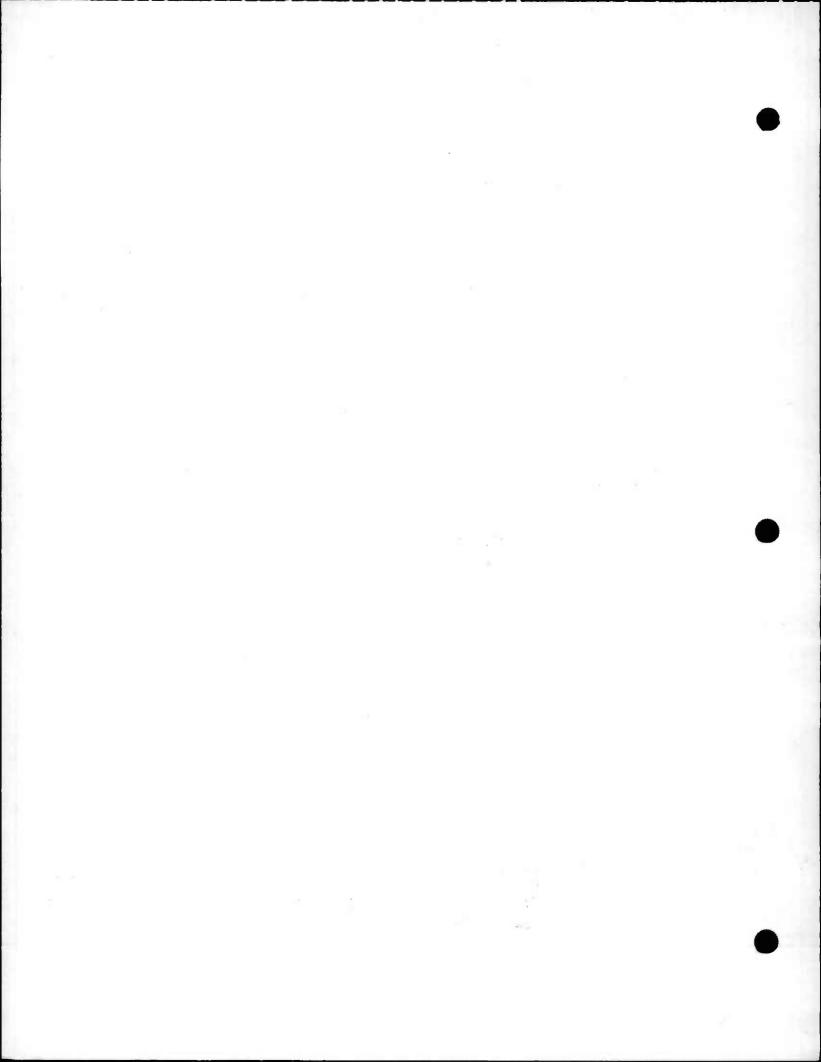
BALTIMORE, MARYLAND 21215-0020	with the law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	in care has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be acted by the attendand Mental Hydrene prior to burial, cremation, or removal.	he medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	TO THE FUNERAL DIRECTURE ALTO SENTICATE has been signed by the attending physician and completely filled in by the fi be filed within 72 hours and common in State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 manual or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	HEGISTRAN			-HILL	ICATE OF	DEAL	1 [	REG. NO	).		
	1. DECEDENT'S NAME (First, Middle, IRWIN	(Last)		н	ERMAN	-			DAY 100	YEAR	3. TIME OF DEATH 1 P. M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las					APRIL 28	, 199		
	578-10-4067	1 🗀 M 2 🗆 F	79	YRS.	F UNDER 1 YEAR MONTHS DAYS	HOURS	MIN.	7. DATE OF BIRTH (Month, Day, Year)	1916	Country	PLACE (State or Foreign y) YLAND
_	9a. FACILITY NAME (If not institution				9b. CITY, TOWN	OR LOCATIO	ON OF OE			NTY OF D	
DIRECTOR	935 LOMBARDY (				GLEN	BUR	NIE			ANNE	ARUNDEL
띭	10a. STATE 10b. C	COUNTY		10c. CIT	Y, TOWN OR LOCAT	TION					10d. INSIDE CITY
	MARYLAND  100. STREET AND NUMBER	ANNE ARU	NDEL			BUR					VES 2 NO
FUNERAL	935 LOMBARDY	CIRCLE			101	f. ZIP CODE		21060		izen of w USA	HAT COUNTRY?
5	11. MARITAL STATUS		TEVER IN U.S. AB	MED	13. WAS DEC	ENDENT O	F HISPANI	C ORIGIN? (Specify Y	s or No-	14. RACE	- American Indian,
BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE V				2. NO		, Puarto Rican, etc.)		Specia	WHITE
COMPLETED	15. DECEDENT (Specify only highes	S EDUCATION I grade completed)	(G/	ve kind of v	USUAL OCCUPATION	ON osl of workin	ng	16b. KIND OF BI	JSINESS/INC	USTRY	
PLE	Elementary/Secondary (0-12)	College (1-4 or 5	+)	NAGE!	7.57			GINOS	REST	ALIBAN	ידיק
S S	17. FATHER'S NAME (First, Middle, La					18. MOTH	HER'S NAM	IE (First, Middle, Maide		10101	<b>11</b>
BE C	MORRIS	HER	RMAN					BELLMAN	,		
TO B	19a. INFORMANT'S NAME (Type/Prin	0)	19t	MAILING	ADORESS (Street a			oute Number, City or To	wn, State, Zip	Code)	
F	MRS. MINNIE	HERMAN		935	LOMBAR	DY C	IRCLE	GLEN BUE	RNIE,	MD 2	21060
	20a. METHOD OF DISPOSITION  1 🔀 Burlat 2 🗆 Cremation 3 🗆  4 🗆 Donation 5 🗀 Other (Specify		20b. PLACE A	ND DATE	OF DISPOSITION (Ne	30-19	995		DALE,		wn, Stata
	21. SIGNATURE OF SUNERAL SERV	ICE LIGHNSEE			22. NAME AI	ND ADDRES	SS OF FAC			TID	
	· Cem (	llan Ley	is		6010	REIS	STERS	TOWN ROAL	BALT	TIMOR	RE, MD 21215
	23. PART I. Enter the disease	s, or complications the	it caused the de	eth. Do r	not enter the mo	da of dyl	ng, such	as cerdiac or reap	olratory arr	est,	Approximate
ļ	IMMEDIATE CAUSE (Final										Interval Between Onset and Death
	disesse or condition resulting in death)	. 1	-21+E		FIZS		00	SEASE	5		YYRS,
_		DUE TO	(OR AS A CONSEC	UENCE O	F):						
CERTIFICATION	Sequentially list conditions, if any, laeding to immediate	b. DUE TO	(OR AS A CONSEC	UENCE OF	<b>ም</b> ):						
CA	Cause. Enter UNDERLYING CAUSE (Disease or Injury	c									
	that initiated events resulting in death) LAST	DUE TO	(OR AS A CONSEO	UENCE OF	F):						
CE	133-11-32-32	d									-i
MEDICAL	PART II. Other significant con			eaulting I	in the undarlying	cause g	iven in P	Part I. 24a. WAS AI		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă	MICOLOS	((HRONIC)	85-00V	MIC	4 10	CRY	rico	1 TYES	2 NO		COMPLETION OF CAUSE OF DEATH?
~		-HOSCS	1165 05 05 1			1		-/			1 TYES 2 NO
AN	DID TOBACCO USE CO				S L NO L	UNC	ERTAIN	IA .			
PHYSICIAN:	EXAMINER?	HOSPITAL:	ER/Outpatient 3		OTHER:	-202	14				
Ŧ	27. MANNER OF DEATH	28a. DATE OF	INJURY	28b. TIM	E OF 28c. INJ	URY AT		Other (Specify) 28d. DESCRIBE HOW	INJURY OCC	URED	
BY P	1 Natural 5 Pending 2 Accident Investig		lay, Year)	INJ		PRK? YES 2 _					
E0 8	3 Suicide 6 Could n 4 Homicide determin	ot be 28e. PLACE O building.	F INJURY At hor atc. (Specify)	ne, farm, s	street, factory, offic	•		261. LOCATION (Street City or Town, State	and Number	or Rural Ru	oute Number,
E I											
COMPLET		PHYSICIAN: To the best of AMINER: On the bests of e									and manner as stated.
	296. SIGNATURE AND TITLE OF CE	TIFIER /	. \			29& LICE	NSE NUME	BER	29d. DATE	E SIGNED	(Month, Day, Year)
TO BE	(leub fil	Man	us_			A.	258	07	•	4/2	8/85
	1406 S. CRK	HW HW	SE OF DEATH (ITEM	27) (Type,	Print) GLE	N BO	YRN	riE Mi	\$ 2	100	61
	MAY U 2 1995	32. MGISTA	BA FEWARE								- 1

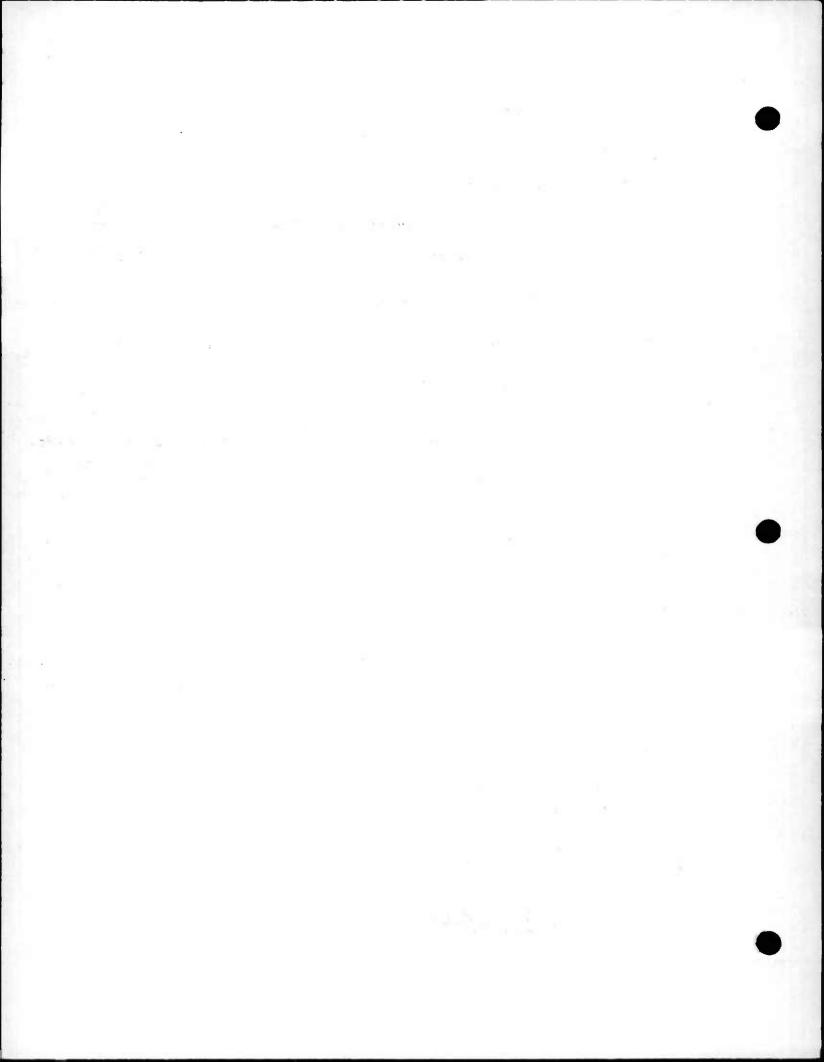


		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT 0	F HEALTH AND I	MENTAL HYGIEN		
	10000	1. DECEDENT'S NAME (First, Middle, Last)  JAMES	LAMAR	HZ	M		2. DATE OF DEATH MONTH APRIL 27,	**1995 *E	ar 1229 A
P		4. SOCIAL SECURITY NUMBER 578 42 6593	1X M 2 🗆 F 6	(In yrs. lest birthday) 2 YRS.	IF UNDER 1 YE		7. DATE OF BIRTH (Month, Day, Year) Jul 1 19	32 5.	BIRTHPLACE (State or Foreign Country)
2, 3 should	стов	9a. FACILITY NAME (# not institution, give str 1224 C SCOTTS RESIDENCE OF DECEMENT				WN OR LOCATION OF DE	EATH	9c. COUNTY Anne	of DEATH Arundel
i. Pages 1,	DIREC	10s. STATE 10b. COUNTY	Arundel		y, town on L				10d. INSIDE CITY LIMITS? 1 YES X NO
n. nnsit permit,	FUNERAL	100. STREET AND NUMBER 1224 C Scotts	Manor			101. ZIP CODE 2111	3	10g. CITIZEN USA	OF WHAT COUNTRY?
-0020 ing physician, the burial-transit	BY FUN	11. MARITAL STATUS  1 Never Merried 2 Married  3 Wildowed 4 V V V V V V V V V V V V V V V V V V	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	If ye	DECENDENT OF HISPAN B, specify Cuben, Maxica YES X NO Specify	n, Puarto Ricen, atc.)		RACE — American Indian, Black, White, etc. Specify:
Z1Z15-0020 lal or attending physic for use as the burial	8	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	vork done durin se retired.)	PATION g most of working	166. KIND OF BU	SINESS/INDUST	
YLAND 21 by the hospital or be detached for u at once.	COMPLET	12th 17. FATHER'S NAME (First, Middle, Last) Bertram G. Har	n	Meci	nanic		ME (First, Middle, Maiden Se Gertru		
retained 5 should notified	TO BE	190. INFORMANT'S NAME (Type/Print)  Elaine Trzciet				eet and Number or Aural I	Route Number, City or Tox	vn, State, Zip Cod	(a)
I I I MORE,  Page 6 may be ral director, page		20e. METHOD OF DISPOSITION  1	rai from Stata cerri	PLACE AND DATE of	of Disposition ther place)  Crei	natory	4/30 Ba	altimo	or Town, Stata
SAL r death re fune al.		- Ilames ()	Horobi	than	Hai	Annar	neral Ho	1 2140	A., 12 Ridge 1
24 hours filled in I tion, or re the med		23. PART I. Enter the disesses, pr co ahock, pr heert feliure. L IMMEDIATE CAUSE (Finel disesse pr condition resulting in death)	st only one ceuse on e	ech line.		mpde of dylng, suc	n aa cerdiac or resp	iratDry errest,	Approximata interval Batween Onsat and Death
X 68.	RTIFICATION	Sequentially list conditiona, If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events		CONSEQUENCE OF					
t the death certificate by the attending physici and Mental Hygiene prior injury, or other tra	CERTI	rasulting in death) LAST							
	MEDICAL	PART II. Other significant conditions	contributing to deeth b	ut not resulting	n the under	lying ceuse given in	Part I. 24a. WAS AN PERFOI	RMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
law rec as beer bept. of	AN:	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL		F DEATH YE			N 🖾		1 TYES 2 X NO
VIII/ CIAN: The prifficate he State or Item	YSICI	1 X YES 2 NO	HOSPITAL:   I   Inpatient   2X ER/Outp	etlant 3 DOA	OTHER: 4   Nursing	Home 5 - Residence	8 Other (Specify)		
NOW OF VILLA NOWE PHYSICIAN: The EASTER this certificate h I manked, or item	ву Рну	27, MANNER OF DEATH  1 XNetural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)		M 1	INJURY AT WORK?	28d. DESCRIBE HOW	NJURY OCCURE	D
R AN EN	ETED.	3 Suicide S Could not be detarmined	28a. PLACE OF INJURY building, atc. (Spec	iny)			281. LOCATION (Street City or Town, State)		ural Route Number,
Y.	COMPL	(Check only one) 2 MEDICAL EXAMINER	AN: To the beat of my knowledge.  On the basis of examination						use(a) and menner ea stated.
TO THE P TO THE P De filed v	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER	nhous			29c. LICENSE NUN	187	≥ 27	NED (Month, Day, Year)  Npr 95
12	-	30. NAME AND ADDRESS OF PERSON WHO WILLIAM ICENHOWS	ER, M.D.			ARMY HOSE	PITAL, FT.	MEADE,	MD 20755
		NIAY U 2 1995	23 ASSESTENT ASSES	druke					



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DIVISION OF VILAL RECORDS, I	The
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-	IOSPITAL OR ATTENDING PHYSICIAN: TH
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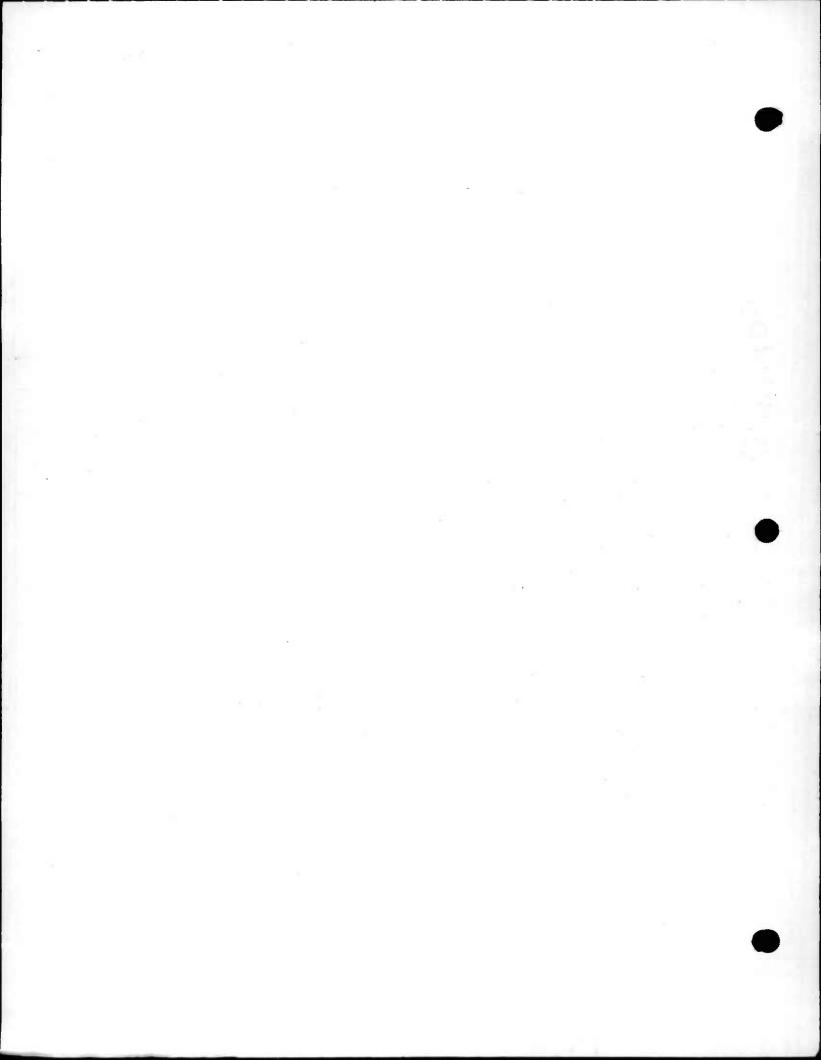
		1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF H		MENTAL HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Last)  DAVID HUDSON	√ ^{AKA} Davi	id B.Hu			2. DATE OF DEATH		3. TIME OF DEATH	
should		4. SOCIAL SECURITY NUMBER  216-32-2364  90. FACILITY NAME (If not institution, give st	1 <del>M</del> M 2 □ F 5	(In yrs. lest birthday) 59 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Oct.3,1	935 Ma	BIRTHPLACE (State or Foreign Country) aryland	
2,3	TOR	Harbor Hospita				or Location of or O. City,		9c. COUNTY	of DEATH none	
DAV. physician. burial-transit permit. Pages 1,	DIRECTOR	Maryland 10b. COUNTY	none		ry, town or located to.Cit				10d. INSIDE CITY LIMITS? 1XXYES 2 \( \square\) NO	
n. ansit perr	FUNERAL	100. STREET AND NUMBER	3 Jackson	St.	101	1. ZIP CODE 21230			of what country?	
TAIND CICIONO the hospital or attending physician detached for use as the burial-tran once.	B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEOENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR OF 3/16/54	2 NO	If yes, sp	CENOENT OF HISPAR secify Cuben, Mexica 3 2 70 Specify	NIC ORIGIN? (Specify Year, Puerto Ricen, etc.)		RACE — American Indian, Black, White, etc. SpecifyWhite	
D Z I Z I Z I Z I Z I Z I Z I Z I Z I Z	PLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) 12th.Grade		18e. OECEDENT'S (Give kind of a life. Do NOT us	USUAL OCCUPATIO		166. KINO OF BU		ver Co.	
by the hospita be detached at once.		17. FATHER'S NAME (First, Middle, Last)	vid B.Huds			18. MOTHER'S NA	ME (First, Middle, Maiden			
retained 5 should		19e. INFORMANT'S NAME (Type/Print)		19b. MAILING		and Number or Rural I	Route Number, City or Tov	vn, State, Zip Coo	de)	
ay be		Ms.Kerry Zimme  20e. METHOD OF DISPOSITION  20e. Method Of DISPOSITION  20e. Method Of DISPOSITION  3   Remo	OSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or To							
teath. Pagr funeral dir xamlner		21. SIGNATURE OF FUNERAL SERVICE LICE		rownsvi	22. NAME AN	ND ADDRESS OF FA	CILITY	Balto.	Md.21230 E.Fort Ave.	
of confidence be executed within-cal hours after the attending physician and completely filted in by the attail tyglene prior to burial, cremation, or removal.	ERTIFICATION	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, ahock, or heart feliure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):								
law requires that the death as been signed by the atter bept. of Health and Mental 23 shows any injury, o	CAL C	PART II. Other significant conditions					Part i. 24a. WAS AN PERFOI	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATHY  1 YES 2 NO	
1 2 8 9 6 1	SICIAN:	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEAT		UNCERTAIN	VO			
Sician: The lar certificate has h the State Dep	PHYSIC	1 YES 2 HO	HOSPITAL: 1 Inpatient 2 ER/Outp. 28e. DATE OF INJURY	partient 3 DOA		e 5 Residence	6 Other (Specify) 28d. DESCRIBE HOW	IN HIBA OCCUBI	50	
F st # 5	B	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year) 28e. PLACE OF INJURY	INJ	M 1 Y	PRK? YES 2 NO				
OR ATTENDING DIRECTOR: After hours after death	ETED	4 Homicide determined	building, etc. (Spec	clfy)			281. LOCATION (Street City or Town, State)	)	ural Route Number,	
	COMPLET		CIAN: To the best of my knowledge.  CIAN: To the basis of examination						use(e) and menner ee stated.	
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: II	TO BE C	SIGNATURE AND TITLE OF CENTIFIER	M).			29c. LICENSE NUN HS 2441		29d. DATE SIG	1 28 1995 ·	
5+1	ĭ	DR. RAYHUYEER SHE	O COMPLETED CAUSE OF DEA	Scol HAN	JOVER 37			SPITAL	BALTIMORE	
		MAY 0 2 1995	A STEEL THAN VO.							



DIVISION OF VITAL RECORDS, P.O. BOX 68760

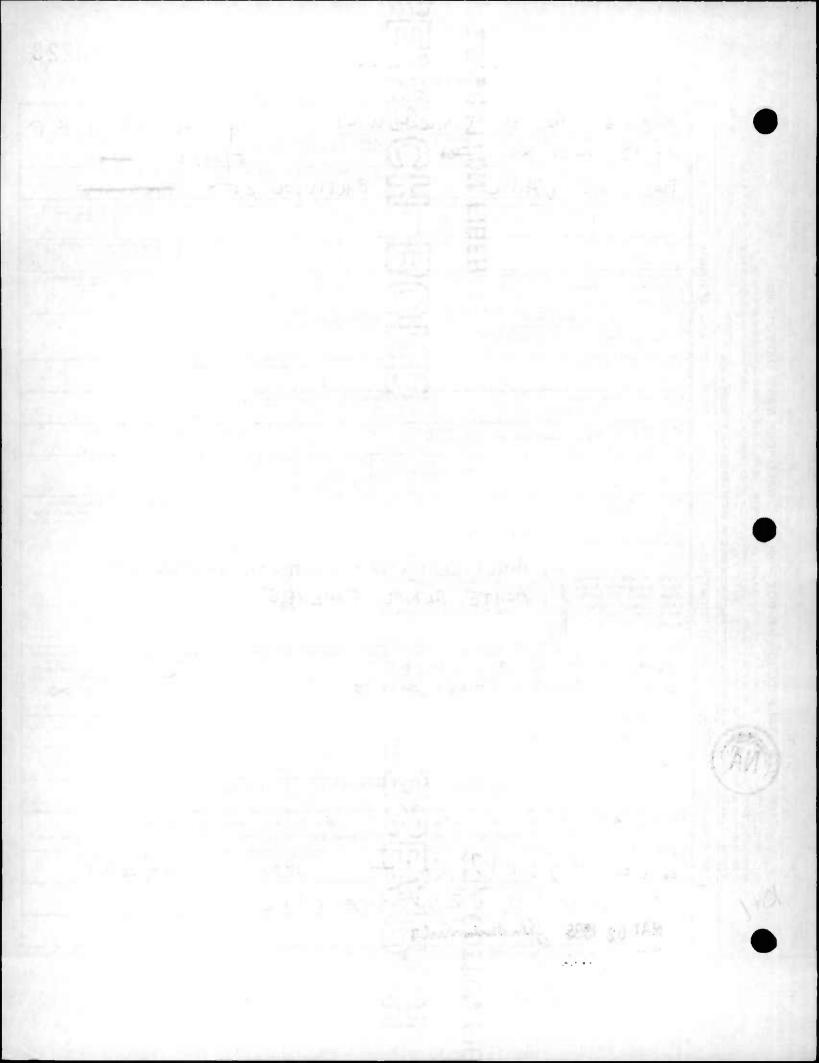
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 Virginia Hodges April 21, 8:45 A M 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 5. SEY 8. AGE (In yrs. leat birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 223-12-2248 1 M 2X F 76 YRS. 9-29-18 Virginia on and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should to burial, cremation, or removal, 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Bel Forest Nursing & Rehab. Center Forest Hill Harford RESIDENCE OF DECEDENT 10a, STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Harford Forest Hills 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 109 Forest Valley Road 21050 U.S.A. hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-BALTIMORE, MARYLAND 21215-0020 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 27 If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 Never Married 2 Married B₹ 1 YES 2 NO Specify: Specify: 3 🔀 Widowed 4 🗌 Divorced white COMPLETED 15. DECEDENT'S EDUCATION 16a. OECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) OWN HOME 6 Housewife notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) (UNKNOWN ) Jones Justine Crawford BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Wanda Correll 21 Wilderness Rd., Elkton, MD 21921 e 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE must 1 Burial 2 Cremation 3 Ramovat from State
4 Donation 8 Other (Specify) examiner SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY State Anatomy Board onald Wade, Dir. men 655 W. Baltimore St., Balto., MD 21201 medical 23. FART I. Enter the diseases, or complicatione that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. interval Betwe IMMEDIATE CAUSE (Final Onset and Death the disease or condition resulting in death) 1 cumonice day traumatic event. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within DUE TO (OR AS A CONSEQUENCE OF): Bronchiec CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING een signed by the attending physician in of Health and Mental Hygiene prior to CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Injury, or PART II. Other aignificant conditions contributing to deeth but not recuiting in the underlying ceuse given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? PERFORMED? shows any Dementiq 1 YES 2 NO 1 TES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN X has b. Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h Item EXAMINER? HOSPITAL: OTHER: 1 Inpetient 2 I ER/Outpetient 3 I DOA insing Home 5 - Residence 8 - Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c, INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural
2 Accident 1 YES 2 NO BY After 1 death 28a. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) .00 ETED. e Could not be OIRECTOR: A 4 Homicide 28 determined Hem COMPL 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL
TO THE FUNERAL (
be filed within 72 h
IMPORTANT: If II (Check only one) HOSPITAL 2 MEDICAL EXAMINER: On the basis of ax stion and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIONEO (Month, Day, Year) BE 4-24-95 5 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MAY 02 1995 32, REGISTRAR'S SIGNATURE

" Clear Rardall

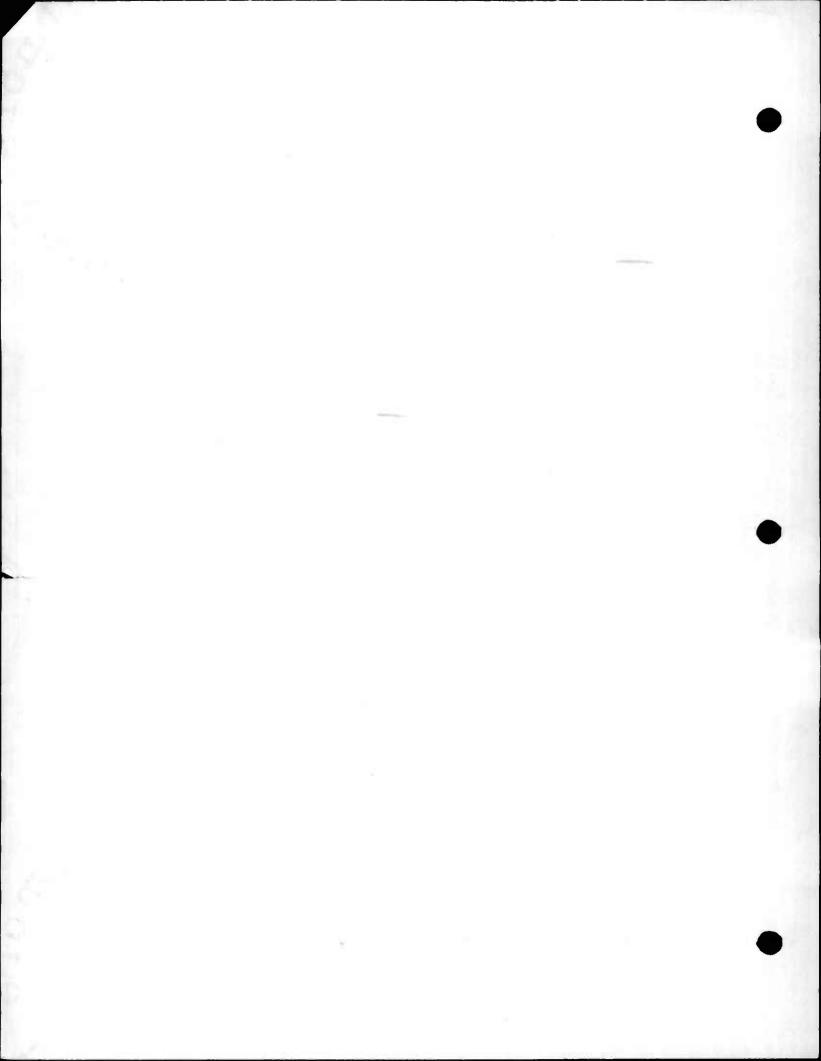


he law requires that	to has been signed by	of sult Dept. of Health and	6 dem 23 shows any	
TO THE HOSPITAL OR ATTENDING	TO THE FUNERAL DIRECTUL AND THE	be filed within 72 hours and deant sup-	MPORTANT: If Item 28 In marked	

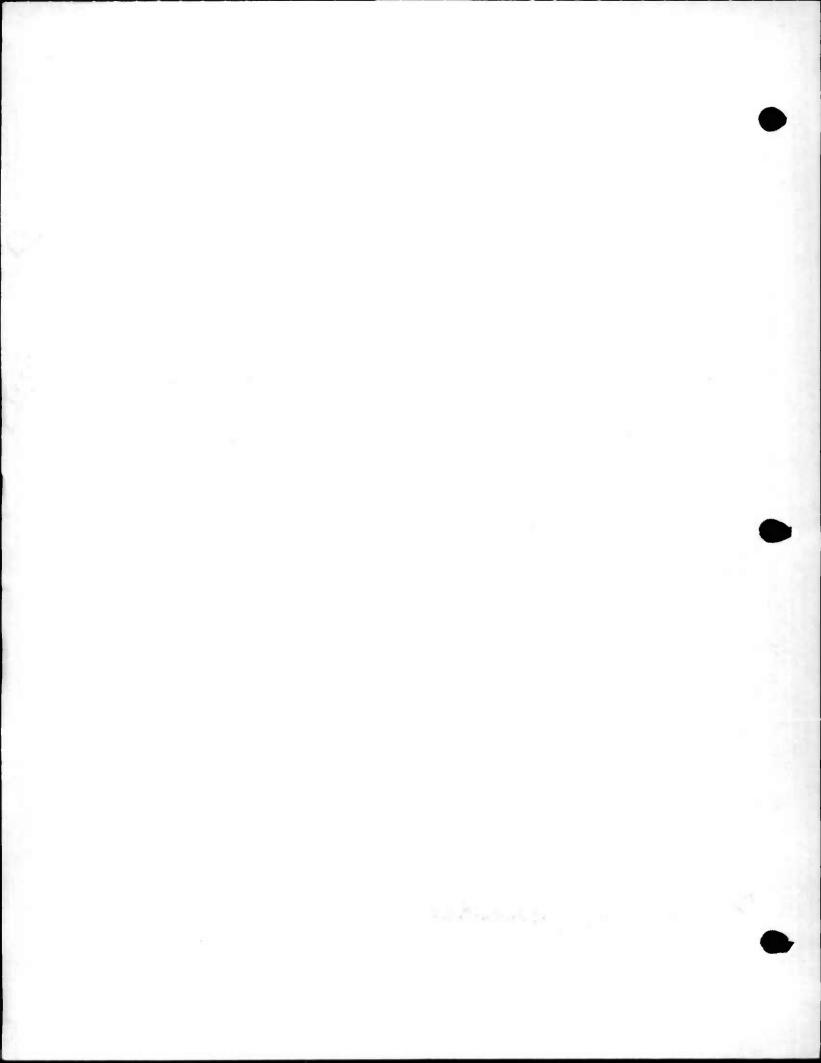
	1 - FOR STATE OF REGISTRAR			ICATE OF			AL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)  AMBROSE CHESTER	JANU	4 CHO	WSKI		2, DA	TE OF DEATH	6 9	3. 1	8,50 PM
	4. SOCIAL SECURITY NUMBER 5. SEX 214-12-44-26 1 1 1 1 2 0 F	6. AGE (In yrs. I		IF UNDER 1 YEAR MONTHS DAYS		AIN. (MC	E OF BIRTH only Day, Year)		Country)	CE (State or Foreign Maryland
TOR	BALTIMARE (If not institution, give street and number)  BALTIMARE VAMC			BACT	MORI		TT		NTY OF DEATH	
DIRECTOR	Md. 106. COUNTY N/A			y, town on Locat altimore	ION		10d. INSIDE CITY LIMITS? 1 P YES 2 NO			
FUNERAL	3804 Foster Avenue			101	21224			10g. CITIZE	N OF WHAT	COUNTRY?
B	1 Never Married 2 Married FORCES?  IF YES, GIVE	NT EVER IN U.S. / 1X YES 2 WAR OR DATES	ARMED NO	If yes, sp	ecity Cuban, k	IISPANIC ORK fexicen, Puer Specify:	GIN? (Specify Ye e Rican, etc.)		4. RACE — A Black, Wh Specify: Thite	American Indian, lite, atc.
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  1 2  College (1-4 or 1 2)	(+)	(Give kind of life. Do NOT us	usual occupation work done during mose retired.)  officer	st of working	1	Baltim			> a
BE CON	17. FATHER'S NAME (First, Middle, Last) John Januchowski						t, Middle, Meidei SORKOWS			
TO B	19a. Informant's name (Type/Print) Dorothy Januchowski		3804	Foster A	Number or	Balto	mber, City or Tox	vn, Stata, Zip C 21224	ode)	1,2==116
	20s. METHOD OF DISPOSITION  1 🔀 Burlal 2 🗆 Cremetion 3 🗆 Removal from State  4 🗆 Donation 6 🗆 Other (Specify)	20b. PLAC cemetery, o Sacr	EANDDATE	of disposition (Na ther place) art of J	esus (	Cem. 4	-29-95	Dund	alk,M	State Id.
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  Charl; es S. Zeiler & Son Inc. 901 S.Conkling St. Balto., Md.  23. PART i. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such se cerdiec or respiratory arrest, Approximata									
TION	shock, or heert feilure. Liet only one of IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	luse on each iid	ne. BEOUENCE O	n: CORY D			S YVV			Approximate interval Between Onset and Daeth
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	O (OR AS A CONS	ENM SEQUENCE O	- FAH Pi:	LUR	E				
MEDICAL	SQUAMOVS ESOTHAGEA	L CAN	JCER		ceuse give	en in Part i.	24a. WAS AI PERFO 1 TYES	RMED?	CON OF	RE AUTOPSY FINDINGS ILLABLE PRIOR TO APLETION OF CAUSE DEATH? YES 23500
SICIAN	25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1   YES 2   NO   1   Input   1   Input   1   Input   1   Input   1   Input   1   Input   1   Input   1   Input   1   Input   Input   1   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input   Input	☐ ER/Outpatient	3 [] DOA	OTHER:	ACE OF DEAT					
BY PHYSICIAN:	27. MANNER OF DEATH 28s. DATE (		28b. TIM	URY WO		28d. C	ESCRIBE HOW	INJURY OCCU	RED	
	3 Suicide a Coult and 200. PLACE	OF INJURY At I	home, farm,	street, factory, offic		261. LI	OCATION (Street ty or Town, State	end Number or )	Rural Route	Number,
COMPLETED	29e. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of MEDICAL EXAMINER: On the best of									l menner as stated.
O BE	and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of t	) Res	siden	+	29c. LICENS			29d. DATE :	ZG 9	oth, Day, Year)
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CA		TIN	Print)	VAN	1C		·		
	31. DATE FILED Month, Day, Year)	TAR'S SIGNATURE	64							



		1 - STATE STATE REGISTRAR	OF MARYLAND / DEPAR CERTIF	TMENT OF HEALTH AND	MENTAL HYGIENE REG. NO.	
		DECEDENT'S NAME (First, Middle, Lest)	RDON JENKTI	MC	4 07 0	3. TIME OF DEATH
Should		4. SOCIAL SECURITY NUMBER 5. SEX 217-38-9086 1 💟 M 2 9a. FACILITY NAME (If not institution, give street end num	6. AGE (In yrs. lest birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.  9b. CITY, TOWN OR LOCATION OF C	7. DATE OF BIRTH (Month, Day, Year) 2 - 01 41	BIRTHPLACE (State or Foreign Country)  MARYLAND  TY OF DEATH
Pages 1, 2, 3	CTOR	SANDTOWN-WINCHESTER NUE	SING HOME	BALTIMORE		
	DIRE	MARYLAND 106. COUNTY		Y, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1  YES 2  NO
5-0020 nding physician. ss the burial-transit permit.	FUNERAL	1 Never Merried 2 Married FORCES	CEOENT EVER IN U.S. ARMED 37 1 TYES 2X XNO GIVE WAR OR DATES	10f. ZIP CODE  21217  13. WAS DECENOENT OF HISPA If yes, specify Cuban, Maxic 1 □ YES 2X NO Spec	INIC ORIGIN? (Specify Yes or No 1	EN OF WHAT COUNTRY?  14. RACE — American Indien, Black, While, atc. Specify:
E all as	ED BY	3 Wildowed 4 Divorced  15. OECEDENT'S EDUCATION (Specify only highest grade completed)	18e. DECEDENT'S	USUAL OCCUPATION work done during most of working	16b. KIND OF BUSINESS/INOU	BLACK
th certificate be executed within-car nows the death Page 6 may be retained by the hospital or the ending physician and completely filled in by the formal directs page 5 should be detached for use thy given prior to burial, cremation, or remove or other traumatic event, the medical examiner must be notified at once.	COMPLET	Elementary/Secondary (0-12) College (1-	4 or 5 +) ##e. Do NOT us	ITER HELPER		1
	BE CO	17. FATHER'S NAME (First, Middle, Lest)	PERS JENKINS	18. MOTHER'S N.	AME (First, Middle, Maiden Sumeme)	
	TO B	19e. INFORMANT'S NAME (Type/Print)	19b. MAILING 2728	3	ANGIF McCORD  Route Number, City or Town, State, Zip C	
		PODNEY JENKINS  20e. METHOD OF DISPOSITION  1	20b. PLACE AND OATE Cometery, cremetory or o		DATE 20c. LOCATION — CI	
		21, SIGNATURE OF FUNERAL SERVICE LICENSES	ene	22. NAME AND ADDRESS OF F	MILLIAM C. BE MINAVE. BALTO. MI	ROWN COMMUNITY 21217
	CAL CERTIFICAT	23. PART / Enfer-the diseases, or complication shock, or heart failure. List only or IMMEDIATE CAUSE (Final disease or condition resulting in death)	ne that caused the daeth. Do ne cause on each line.	ge kend	ch as cardiec or respiratory arrest	Approximata interval Between Onast and Death
		cause. Enter UNDERLYING CAUSE (Disease or injury	UE TO (OR AS A CONSEQUENCE OF	Controst.	of far long	Tyus
THE RECORDS,  The law requires that the dea te has been signed by the atl ate Dept. of Health and Menta em 23 shows any Injury,		PART II. Other algnificent conditions contribute	ng to death but not reculting I	in the undarlying cause given in	Part I. 24a, WAS AN AUTOPSY PERFORMEO?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH?  1 YES 2 NO
has has	SICIAN:	DID TOBACCO USE CONTRIBUTE TO	28. PLACE OF DEATH  28. PLACE OF DEAT	NO UNCERTAL	Ν□	
	IYSIC		nt 2 - ER/Outpatient 3 - DOA	OTHER:		
를 돌돌 후	ВУ РНУ	1 Natural 5 Pending 2 Accident Investigation		WORK?  M 1 YES 2 NO	28d. OESCRIBE HOW INJURY OCCU	REO
TTENDI CTOR: A after da	8	3 Suicide 8 Could not be 4 Homicide determined	ACE OF INJURY — At home, ferm, a stillding, atc. (Specify)	street, fectory, office	281. LOCATION (Street and Number of City or Town, State)	Rural Route Number,
Z Z Z =	COMPLET				to the ceuse(s) and menner ea atated	
물 물을 합	BE C	290. SIGNATURE AND TITLE OF CERTIFIER	h ha	29c. LICENSE NU		SIGNED (Month, Day, Year)
268₹	5	10. NAME AND ADDRESS OF PERSON WHO COMPUSTE	D CAUSE OF DEATH (ITEM 27) (Typo.	Print) 5/66	· Rolling Roll	RULL
5		31. DATE FILEO (Month, Day, Year)	STRAR'S SIGNATURE	/ . / 6 .	- July 19	17 11/1-

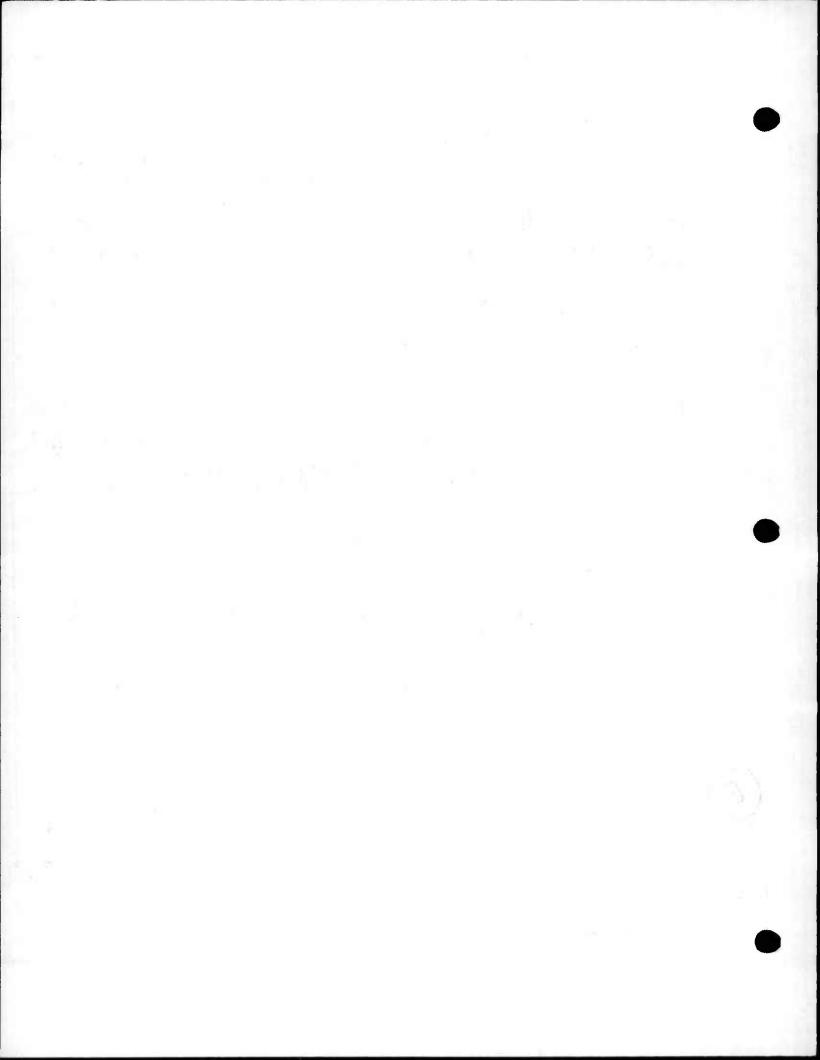


		FOR 1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM			MENTA	REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last)	IONES				2. DATE MONT	OF DEATH DAY	3. 1	THE OF DEATH
<b>020</b> physician. burial-transit permit. Pages 1, 2, 3 should		4. SOCIAL SECURITY NUMBER  220-64-1095  9a. FACILITY NAME (If not institution, give	1)KM2 = 3	5 YRS. MONT		IF UNDER 24 HRS. HOURS MIN.	55 TO	EMBER 1,196	Country)	E (State or Foreign
	TOR	MASON F. LORD RESIDENCE OF DECEDENT	5200 PSTELA	AVENUE.	BAL	TIMORE	EATH EATH		/a	6
	DIRECTOR	MD 10a. STATE 10b. COUNT	n/a	10c. CITY, TO		timore				INSIDE CITY LIMITS?
	FUNERAL		on Ave.			1. ZIP CODE 2120			EN OF WHAT USA	COUNTRY?
215-0020 attending physician	BY FU	11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 42☐XDivorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2XIXINO	If yes, sp	CENDENT OF HISPAP Hecity Cuban, Maxica 2 10 10 Specifi	n, Puarto	N? (Specify Yea or No— Rican, atc.)	Black, Wh	merican Indian, He, etc. Black
10RE, MARYLAND 21. e 6 may be retained by the hospital or ector, page 5 should be detached for u must be notifiled at once.	ETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)		16a, DECEDENT'S USUA (Give kind of work of life. Do NOT use retir	one during mo		180	b. KIND OF BUSINESS/INDU	STRY	
	COMPI	17. FATHER'S NAME (First, Middle, Last)	2yrs.	Gene	eral		ME (First,	Sherman Middle, Maiden Surname)	Willi	ams
	BE		J0nes			Mari	an	Wilson		
	TO E	19a. INFORMANT'S NAME (Type/Print)  Bryant Jones	3					ober, City or Town, State, Zip (		
		20a. METHOD OF DISPOSITION 1		PLACE AND DATE OF DIS	POSITION (Na		DA			
ALT death. e funera al. examin		21, SIGNATURE OF FUNERAL SERVICE L	censee a. Mo	ton	Jam	es A. M	ort	on & Sons St. Balto	Fune	ral Home
OX 68760 B, s be executed within 24 hours after sician and completely filled in by the rior to build, cremation, or removal traumatic event, the medical	CATION	23. PART I. Enter the diseases, or shock, or heart failure.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Sequentielly list conditions, if any, leading to immediate	a. Progress  DUE TO (OR AS A. D. Pet To VI	ch line.		,				Approximate interval Batween Onset and Death  Hwes
P.O. B tth certificate tending phys al Hygiene p or other	CERTIFICA	cause, Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	CDUE TO (OR AS A d. d.	CONSEQUENCE OF):						
icords, I	MEDICAL CE	PART II. Other algnificent condition	na contributing to death bu	t not resulting in the	underlyin	g ceuee given in	Part I.	24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 10	COM OF D	E AUTOPSY FINDINGS LABLE PRIOR TO PLETION OF CAUSE JEATH?  YES 2 \( \subseteq \text{NO} \)
Sept a		DID TOBACCO USE CONT				UNCERTAIN	۱ 🗆			
N: The hicate h State h	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO	HOSPITAL: 1   Inpatient 2   ER/Outpa		HER:					
HYSICIA HYSICIA HIS certif His certif with the ted, or	PHY	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME/OF	28c. INJ	URY AT		or (Specify) SCRIBE HOW INJURY OCCU	RED	
ON OD ON OTHER PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF T	BY F	Natural 5 Pending Investigation	(Month, Day, Year)		1 0	PRK? YES 2 NO				
TTENDI TTOR: A after d	8	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY - building, atc. (Specif	- At home, farm, atreet,	factory, offic	•		ATION (Street and Number of Town, State)	Rural Route i	Number,
보 내 전 보	COMPLET		ER: On the best of my knowle							manner as stated.
TO THE HOSPIT TO THE FUNER De filed within 7	TO BE	296. SIGNATHRI AND TITLE OF CERTIFIE	D Fellow			NUTTE NUM	148	29d, DATE	SIGNED (Mon	th, Day, Year)
7	-	30. NAME AND ADDRESS OF PERSON WI	COMPLETED CAUSE OF DEA	/ 16	easoe	> Johns	Her	kas Hogail	N Ba	Uthrave
V		MAY 02 1995 A	Mark to special supplies							



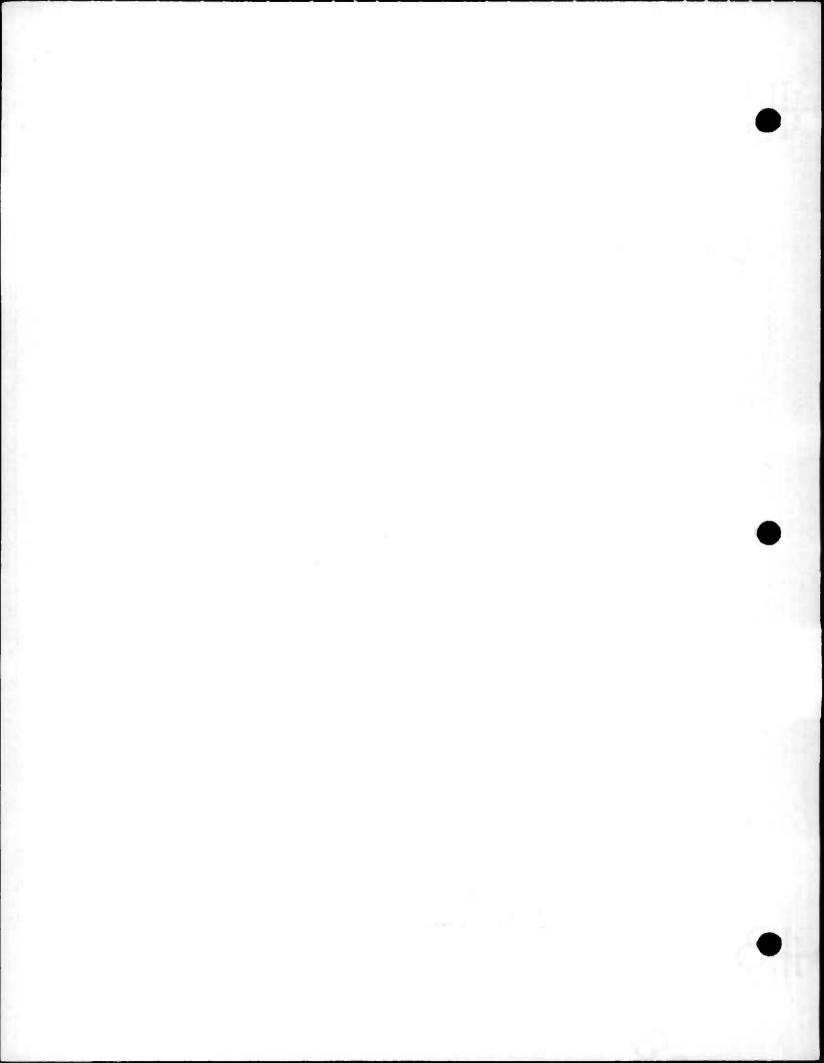
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		1 - STATE REGISTRAR	OIRIE OF MAITE	AND / DEPARTMENT OF CERTIFICATE O		MENTAL HYGIE! REG. NO		
		1. DECEDENT'S NAME (First, Middle, Last)	)			2. DATE OF DEATH		3. TIME OF DEATH
			LES	JOH	NOSUN	4 3	A 100	+ 112P"
		217-07-0868	5. SEX 8. AGE	(In yrs. lest birtndey) IF UNDER 1 YEAR MONTHS DAY		7. DATE OF BIRTH		THPLACE (State or Foreign
3 should	œ	9a. FACILITY NAME (If not institution, give	street and number)	96. CITY, TOW	N OR LOCATION OF DE	EATH PINOS	9c. COUNTY OF	DEATH
2,	стоя	RESIDENCE OF DECEDENT	HUSPI	19 1 50	ITIMIO	re	IN	Π
permit. Pages 1,	DIRE	Maryland	"N/A	10c. CITY TOWN OR LO	more			10d, INSIDE CITY LIMITS? 1 YES 2 NO
isit perm	FUNERAL	100. STREET AND NUMBER	W Rd		21274	5	10g. CITIZEN OF	WHAT COUNTRY?
020 physician. burial-transit	FUN	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT EVER II FORCES? 1 YES	2 NO If yes,	ECENDENT OF HISPAN specify Cuten, Maxica	NIC ORIGIN? (Specify Year, Puarto Rican, etc.)	na or No— 14. RA	ICE American Indian, ack, White, etc.
215-0020 attending physic ise as the burial	р Вү	3 Widowed 4 Divorced	IF VESI GIVE WAR OF A	MATES 1 7	ES 2 NO Specifi		13	Mack
AND 21215-0 the hospital or attending detached for use as the once.	COMPLETED	15. DECEDENT'S EDI (Specify only highest grad Elementspy/Secondary (0-12)		(Give kind of work done during	TION most of working	16b. KIND OF BU	JSINESS/INDUSTRY	
YLAND 2121 by the hospital or atta be detached for use at once.	OMPL	17. FATHER'S NAME (First, Middle, Lest)	0	Iruck I	river)	IWho	lesal	e (0.
2 2 2 E	BE CC	Daniel Ja	ohnson		Sus	ME (First, Middle, Maide	ohn S	on
	2	Marty NAME (Type/Print)	hnson	19b. MAILING ADORESS (Street	1/1 P \/	Source Nymber, City or Tox	wn, State, Zip Code)	1.21225
ALTIMORE, death. Page 6 may be funeral director, page		20a. METHOD OF DISPOSITION 1 METHOD OF DISPOSITION 3 Ram		D. PLACE AND DATE OF DISPOSITION	(Named)	5/5/0 D	OCATION — City or	Town, State
ALTIMO death. Page of funeral direct.		4 Donation 6 Other (Specify)	JCENSEE O O	22. NAME	AND ADDRESS OF FA	17775] UV	vings i	11115,149,
		Joseph	I. Re	115 222	2 W. Nor	Th Ave	Balton	Md, 21216
urs al in by rem			compilications that caused. List only one cause on a	d the death. Do not anter the reach line.	moda of dying, suc	h as cardiac or resp	piratory arrest,	Approximeta Interval Between
2 1 1 5 2		IMMEDIATE CAUSE (Final disease or condition resulting in death)	HAER	rophilus 1	NFLUENE	BA PNE	UMONIA	Onsat and Death
6876C ecuted within and completely burial, cremati attic event, t			DUE TO (OR AS A	A CONSEQUENCE OF):			· · · · ·	
O. BOX 687( sertificate be executed ling physician and com rigiene prior to burial, other traumatic ex	RTIFICATION	Sequentially list conditions, if any, leeding to immediate	OUE TO (OR AS A	A CONSEQUENCE OF):				
BO)	FIS S	CAUSE (Disease or Injury	c					
Pene pe	= 1		DUE TO (OR AS A	CONSEQUENCE OF):				
D 4 5 5	SERTI	that initiated events resulting in death) LAST	DUE TO (OR AS A	A CONSEQUENCE OF):				
ADS, P. at the death of the attend and Mental H	L CE	that initiated events	d		ing ceuse given in	Part I. 24a, WAS AF		4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ADS, P. at the death of the attend and Mental H	CAL CE	thet initiated events resulting in death) LAST	d		ing ceuse given in	Pert I. 24a, WAS AF PERFO	RMEO?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
RECORDS, P. w requires that the death of been signed by the attend tt. of Health and Mental H. § shows any injury, or	MEDICAL CE	thet initiated events resulting in death) LAST	d.	out not resulting in the underly		PERFO	RMEO?	AVAILABLE PRIOR TO COMPLETION DF CAUSE
TAL RECORDS, P. The law requires that the death of the has been signed by the attend are Dept, of Health and Mental Hem 23 shows any injury, or	AN: MEDICAL CE	PART II. Other significant condition  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?	one contributing to deeth b	DEPTH YES NO 28. PLACE OF OEATH (Check only or	UNCERTAIN	PERFO	RMEO?	AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
- VITAL RECORDS, P. ICIAN: The law requires that the death of the series been signed by the attend the State Dept. of Health and Mental H. or Item 23 shows any injury, or	HYSICIAN: MEDICAL CE	PART II. Other significant condition  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CAUSE O	DEATH YES NO  28. PLACE OF DEATH (Check only or  DETHER:  28b. TIME OF 28c. 1	UNCERTAIN  Ome 5 G Rasidence  NJURY AT	PERFO	RMEO? 2 NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
OF VITAL RECORDS, P. PHYSICIAN: The law requires that the death of this certificate has been signed by the attend with the State Dept. of Health and Mental Hited, or Item 23 shows any Injury, or	SICIAN: MEDICAL CE	Thet initiated events resulting in dasth) LAST  PART II. Other significant condition  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5 Pending Investigation	TRIBUTE TO CAUSE O  HOSPITAL: 1 Impartent 2 = ER/Outp  (Month, Day, Year)	DF DEATH YES NO  28. PLACE OF OEATH (Check only or petient 3 DOA 4 Nursing H  28b. TIME OF INJURY M 1	UNCERTAIN  DOME 5 GRasidence  NJURY AT  WORK?  YES 2 NO	PERFO 1 YES 6 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCURED	AMALABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?  1 YES 2 Mg
OF VITAL RECORDS, P. PHYSICIAN: The law requires that the death of this certificate has been signed by the attend with the State Dept. of Health and Mental Hited, or Item 23 shows any Injury, or	TED BY PHYSICIAN: MEDICAL CE	The initiated events resulting in death) LAST  PART II. Other significant condition  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5 Pending	TRIBUTE TO CAUSE O  HOSPITAL: 1 Ill Impatient 2   ER/Outp  28e. DATE OF INJURY (Month, Day, Year)	DEATH YES NO  28. PLACE OF OEATH (Check only or  28. TIME OF INJURY M  1 (  At home, term, street, tectory, of	UNCERTAIN  DOME 5 GRasidence  NJURY AT  WORK?  YES 2 NO	PERFO 1 YES	INJURY OCCURED	AMALABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?  1 YES 2 M8
DIVISION OF VITAL RECORDS, P. TAL ATTENDA G PHYSICIAN: The law requires that the death of Man Physician has been signed by the attend 72 bours again and Mental H. II. m. 28 to Jacked, or item 23 shows any injury, or	PLETED BY PHYSICIAN: MEDICAL CE	Thet initiated events resulting in dasth) LAST  PART II. Other significant condition  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5 Pending Investigation  3 Suicide 6 Could not be detarmined  29e. CERTIFIER (Check only)	TRIBUTE TO CAUSE O  HOSPITAL:  1 Independent 2 ER/Outp  28e. DATE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY building, atc. (Spec	DEATH YES NO  28. PLACE OF OEATH (Check only or patient 3 DOA 4 Nursing H  28b. TIME OF INJURY M  1 CAT home, tarm, street, tactory, of city)	UNCERTAIN  DOME 5 GRasidence  NJURY AT  WORK?  YES 2 NO  Hica	PERFO  1 YES  6 Other (Specify)  28d. DESCRIBE HOW  28f. LOCATION (Street City or Town, State  to the cause(e) end ma	INJURY OCCURED  and Number or Rural	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 1 Mg
DIVISION OF VITAL RECORDS, P. TAL ATTENDA G PHYSICIAN: The law requires that the death of Man Physician has been signed by the attend 72 bours again and Mental H. II. m. 28 to Jacked, or item 23 shows any injury, or	COMPLETED BY PHYSICIAN: MEDICAL CE	Thet initiated events resulting in dasth) LAST  PART II. Other significant condition  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5 Pending Investigation  3 Suicide 6 Could not be detarmined  29e. CERTIFIER (Check only)	TRIBUTE TO CAUSE O  HOSPITAL: 1 [Limpettent 2 = ER/Outp 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, atc. (Spec	DUT NOT resulting in the underly  DF DEATH YES NO  28. PLACE OF OEATH (Check only or  OTHER: 4   Nursing H  28b. TIME OF INJURY M 1   ( — At home, tarm, street, tectory, of	UNCERTAIN  Dome 5 G Rasidence  NJURY AT  WORK?  YES 2 NO  Tica  ste and placa, and due  , death occured at the	8 Other (Specify) 28d. DESCRIBE HOW  28f. LOCATION (Street City or Town, State to the cause(e) end ma	INJURY OCCURED  and Number or Rural inner se stated, and due to the cause	AMALABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?  1 YES 2 Me  / Route Number,
DIVISION OF VITAL RECORDS, P. ATTENDA, G. P. ATTENDA, G. PHYSICIAN: The law requires that the death of PHYSICIAN: The law requires that the death of PHYSICIAN: And this certificate has been signed by the attend own's act, east with the State Dept. of Health and Mental How, as the period of them 23 shows any injury, or them 23 shows any injury, or	PLETED BY PHYSICIAN: MEDICAL CE	Thet initiated events resulting in death) LAST  PART II. Other significant condition  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5 Pending Investigation  3 Suicide 6 Could not be detarmined  4 Homicide 6 Could not be detarmined  29e. CERTIFIER (Check only one)  2 MEDICAL EXAMINI  29b. SIGNATURE AND TITLE OF CERTIFIE	TRIBUTE TO CAUSE O  HOSPITAL:  1 Temperior 2 EP/Outp  28e. PLACE OF INJURY (Month, Dey, Year)  28e. PLACE OF INJURY building, atc. (Spec	DEATH YES NO  28. PLACE OF OEATH (Check only or OTHER: petient 3 DOA 4 Nursing H  28b. TIME OF INJURY M  1 College, death occurred at the time, don and/or investigation, in my opinion	UNCERTAIN  DOME 5 GRasidence  NJURY AT  WORK?  YES 2 NO  Hica	8 Other (Specify) 28d. DESCRIBE HOW  28f. LOCATION (Street City or Town, State to the cause(e) end ma	INJURY OCCURED  and Number or Rural inner se stated, and due to the cause	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 1 Mg
DIVISION OF VITAL RECORDS, P. THE HOSPITAL ATTENDAGE PHYSICIAN: The law requires that the death of the FUNERAL DIPE "Be Arte this certificate has been signed by the aftendined within 72 yours aren earl with the State Dept. of Health and Mental the ORTANT: If Im 28 is jacked, or item 23 shows any injury, or	BE COMPLETED BY PHYSICIAN: MEDICAL CE	Thet initisted events resulting in dasth) LAST  PART II. Other significant condition  DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	TRIBUTE TO CAUSE O  HOSPITAL:  1 Tempertent 2 ER/Outp  28e. PLACE OF INJURY (Month, Day, Year)  28e. PLACE OF INJURY building, atc. (Spec	DEATH YES NO  28. PLACE OF OEATH (Check only or petient 3 DOA 4 Nursing H  28b. TIME OF INJURY M  1 CAT HOME, tarm, street, tectory, of city)  Place of the time, dim and/or investigation, in my opinion  THE (TEM 27) (Type, Print)	UNCERTAIN  DOME 5   Rasidence  NJURY AT  NORK?  YES 2   NO  filca  ste and placa, and due  desth occured st the  29c. LICENSE NUM  PO 77	8 Other (Specify) 28d. DESCRIBE HOW  28f. LOCATION (Street City or Town, State to the cause(e) end ma	INJURY OCCURED  and Number or Rural inner se stated, and due to the cause	AMALABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?  1 YES 2 Me  / Route Number,
THE HOSPITAL ATTENDAG PHYSICIAN: The law requires that the death of the FUNERAL DIPE THE Arthoughts certificate has been signed by the aftendibled within 72 yours aren earl with the State Dept. of Health and Mental the ORTANT: If Im 28 is facked, or litem 23 shows any injury, or	BE COMPLETED BY PHYSICIAN: MEDICAL CE	Thet initiated events resulting in dasth) LAST  PART II. Other significant condition  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5 Pending Investigation  3 Suicide 6 Could not be detarmined  29e. CERTIFIER (Check only one)  2 MEDICAL EXAMINI  29b. SIGNATURE AND TITLE OF CERTIFIER  (Check only one)  30. NAME AND ADDRESS OF PERSON WITH A COURT OF CERTIFIER  31. DATE FILED (Month, Day, Year)	TRIBUTE TO CAUSE O  MOSPITAL: 1 Menter 2 EN/Outp  28e. DATE OF INJURY (Month, Dey, Year)  28e. PLACE OF INJURY building, atc. (Spec	DEATH YES NO  28. PLACE OF OEATH (Check only or petient 3 DOA 4 Nursing H  28b. TIME OF INJURY M  1 CAT HOME, tarm, street, tectory, of city)  Place of the time, dim and/or investigation, in my opinion  THE (TEM 27) (Type, Print)	UNCERTAIN  DOME 5   Rasidence  NJURY AT  NORK?  YES 2   NO  filca  ste and placa, and due  desth occured st the  29c. LICENSE NUM  PO 77	8 Other (Specify) 28d. DESCRIBE HOW  28f. LOCATION (Street City or Town, State to the cause(e) end ma	INJURY OCCURED  and Number or Rural inner se stated, and due to the cause	AMALABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?  1 YES 2 New Number,  I Route Number,



THE HOSPITAL ON OF VITAL RECORDS, P.O. BOX 68/00  TO THE HOSPITAL ON OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  TO THE FUNEAL DIRECTOR, that this certificate has been stigned by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. or Health and Mental Hygher prior to burial, cremation, or removal.  IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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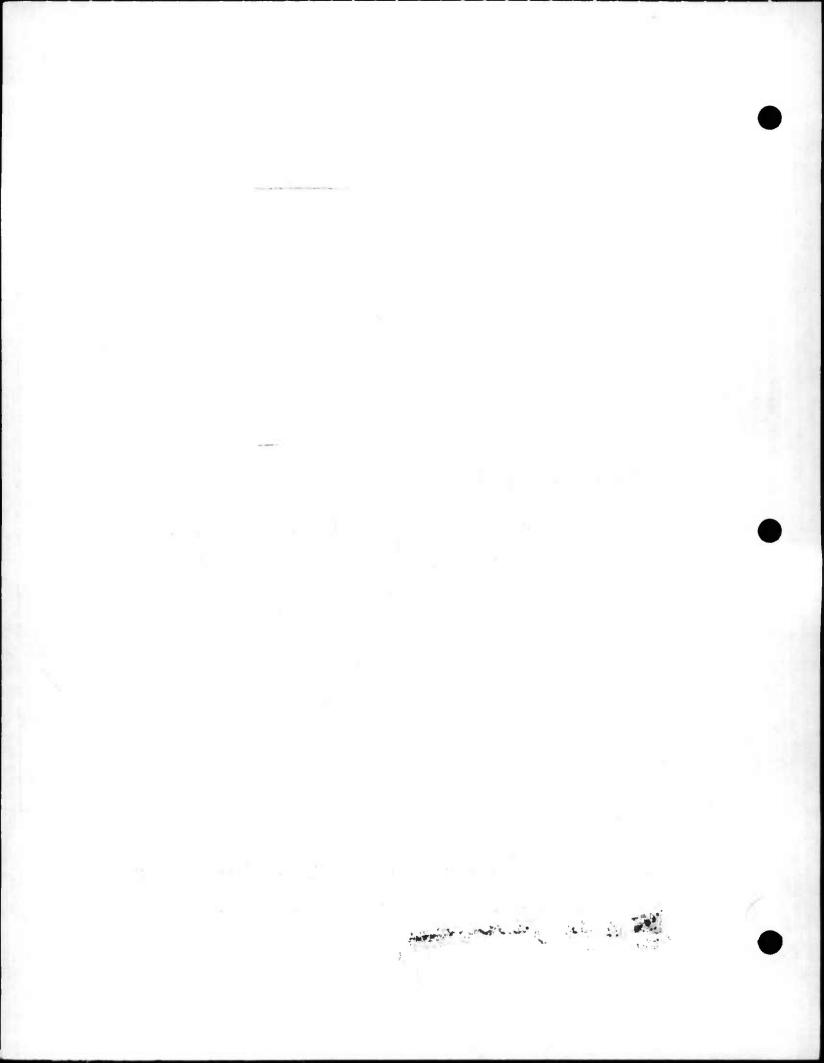
	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last)  ELSIE T. JONES  2. DATE OF DEATH MONTH 04-24-95  \$\frac{1}{2}\text{DAY} = \frac{1}{2}\text{DAY} = \frac{1}{2								
Ì	4. SOCIAL SECURITY NUMBER  220-46-2406  5. SEX  1  M 2 XIX  8. AGE (in yrs. last birthday)  1 F UNDER 1 YEAR  BY UNDER 24 HRS.  F UNDER 24 HRS.  BY UNDER 24 HRS.  F UNDER 24 HRS.  O11-23-04  S. BIRTHPLACE (State or Foreign Country)  MARYLAND								
DIRECTOR	98. FACILITY NAME (If not institution, give street and number)  WESWICK  BALTIMORE CITY  9c. COUNTY OF DEATH  N/A								
REC	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY								
	BALTIMORE CITY XX YES 2 O NO								
FUNERAL	907 HAMLET HILL ROAD  100. STREET AND NUMBER 21210  109. CITIZEN OF WHAT COUNTRY? U.S.A.								
BY	11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES XXNO IF YES, OIVE WAR OR DATES  13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, appetly Cuban, Maxican, Puerto Rican, etc.)  14. RACE — American Indian, Black, White, atc.  15. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, appetly Cuban, Maxican, Puerto Rican, etc.)  16. RACE — American Indian, Black, White, atc.  17. YES XX NO Specify: WHITE								
15. DECEDENT'S EDUCATION 168. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY									
COMPLET	12 YEARS  College (1-4 or 5 +)  HOUSEWIFE  OWN HOME								
BE COI	17. FATHER'S NAME (First, Middle, Last)  GEORGE TUERK  18. MOTHER'S NAME (First, Middle, Meiden Surname)  MARGARET AUHL								
TO E	19a. INFORMANT'S NAME (Types/Print)  MARGUERITE ELSIE HUGHES  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  111 HAMLET HILL ROAD, BALTIMORE, MD. 21210								
	20s. METHOD OF DISPOSITION  1 Buriel 2 Cremetion 3 Removal from State  20b. PLACE AND DATE Of DISPOSITION (Name of genetary, greenetary, g								
	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify ENTOMBM T LORRAINE MAUSOLEUM 4-25 WOODLAWN, MD. 21207 21. SIGNATURE OF FUNERAL SERVICE LORRAINE AND ADDRESS OF FACILITY								
- 126	HENRY W. JENKINS & SONS 4905 YORK ROAD, BALTIMORE, MD. 21212								
23. PART I. Enter the diseases, or complications that caused the desth. Do not anter the mode of dying, such as cardiac or respiratory arrest,									
	IMMEDIATE CAUSE (Fine)								
	disease or condition resulting in death)  a. DEMENTIA - ALZHEIMERS  10 YRS.								
-	PROBABLE RECURRENT MIMI STROKES X-2 3 WEEKS								
CERTIFICATION	Sequentially list conditions, if any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):								
S	csuse. Enter UNDERLYING CAUSE (Disease or Injury								
Ë	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST								
E E	d								
CAL	PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceues given in Part I. 24a. WAS AN AUTOPSY PERFORMED?  AMILABLE PRIOR TO								
ä	A · S · C · V · D · AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?								
Ž.	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAINK								
AN	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)								
Sic	EXAMINER?  1 YES XXNO  HOSPITAL: 1   Inpetient 2   ER/Outpetient 3   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA   DOA								
BY PHYSICIAN: MEDI	27. MANNER OF DEATH  28a. DATE OF INJURY (Month, Day, Year)  28b. TIME OF INJURY AT WORK?  28d. DE\$CRIBE HOW INJURY OCCURED								
	2 Accident Investigation 3 Suicide 8 Could not be Homicide determined  28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify)  28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
COMPLETED	29a. CERTIFIER (Check only one)  WINCERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and manner as stated.    MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated.								
	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)								
TO BE	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)								
	CHARLES O'DONOVAN III M.D., 700 W. 40th. STREET, BALTO., MD. 21211								
	MAY 0 2 1993 July 32 Heris Pars Charles								



DHMH-18 Rev 1/89

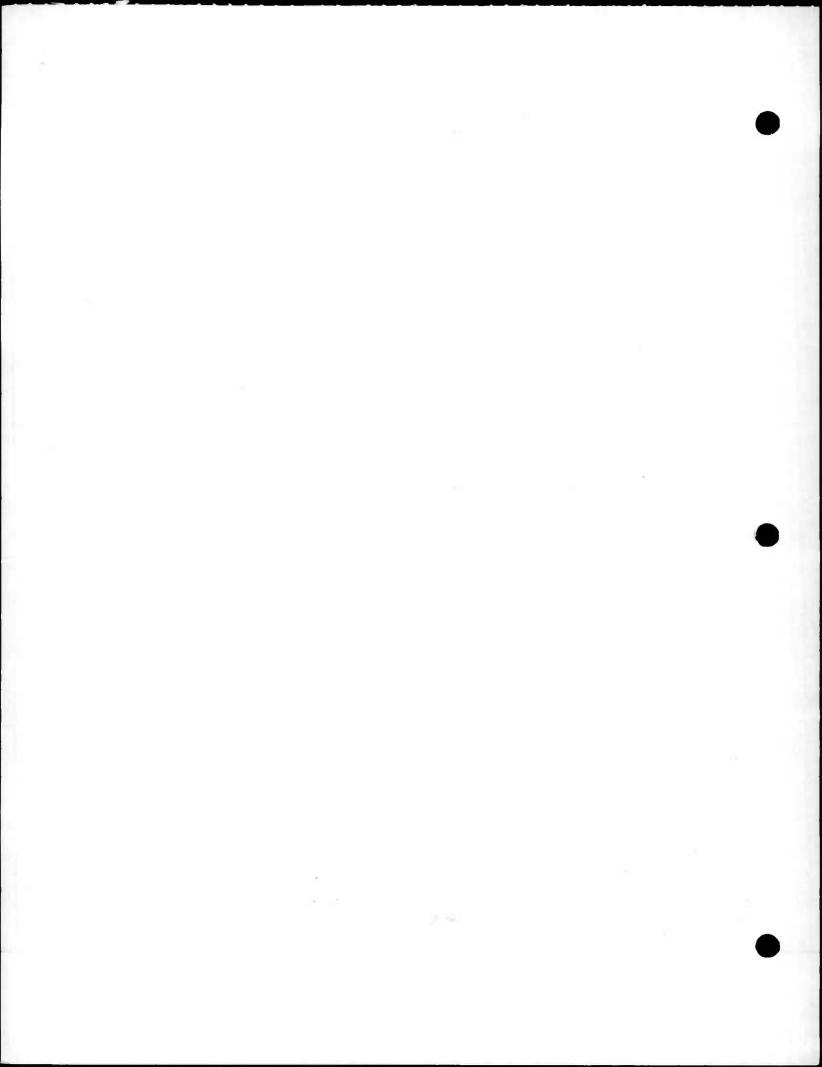
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	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF I		MENTAL HYGIE		
	1. DECEDENT'S NAME (First, Middle, Lest)	Glenn D.				2. DATE OF DEATH MONTH	27,1995	3. TIME OF DEATH 1:30 P. M
	4. SOCIAL SECURITY NUMBER 302-01-3239	1 X M 2 D F	(In yrs. last birthday) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH Jan 18	6.6	RIPTHPLACE (State or Foreign Country) Kentucky
CTOR	9a. FACILITY NAME (If not institution, give a 2015 Red Ri RESIDENCE OF DECEDENT			Elde	or Location of D rsburg lersbur		9c. COUNTY Ca	of DEATH rroll
DIRE	10a. STATE 10b. COUNT			to.Cit				10d. INSIDE CITY LIMITS? MXYES 2 \( \square\) NO
FUNERAL		Charles St		10	21230	100		of what country? d States
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 1 YES IF YES, GIVE WAR OR D	2 NO	If yes, ap		NIC ORIGIN? (Specify ) an, Puarto Rican, etc.) fy:		RACE — American Indian, Black, White, atc. Specify: White
LETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	ork done during mo retired.)	ON ost of working		USINESS/INDUST	
COMPL	9th.Grade	none		ner		AME (First, Middle, Maid	en Sumame)	Ship Yard
TO BE	19a. INFORMANT'S NAME (Type/Print) Linda Willis	Lundy		ADDRESS (Street a		Route Number, City or To	onley	e)
	20a. METHOD OF DISPOSITION 11/2 Burlel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	20t cen	p. PLACE AND DATE On the property, crematory or off. en Have	FDISPOSITION (Na	River Remod	DATE 20c. 1	ocation - city en Bur	or Town, Stata
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY Balto.Md. 21230 McCully Funeral Home, 130 E. Fort							
MEDICAL CERTIFICATION	23. PART I. Enter the diseases, prahock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO JOR AS A	ach lina.	inst ¿ Gr	emo		1	Approximate Interval Between Onset and Daeth
	PART II. Other algnificant condition					1 YES	ORMEDT 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?  1  YES 2 NO
SICIAN:	25. WAS CASE REFERRING TO MEDICAL EXAMINER?		26. PLACE OF DEATH	(Check only one)	/			
РНУ	27. MANNER OF DEATH  1 Netural 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. INJ		6 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCURE	D
ETED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide detarmined	28s. PLACE OF INJURY building, etc. (Spec	' — At home, farm, at city)	reat, factory, offic	•	28f. LOCATION (Stree City or Town, State		urel Route Number,
COMPLE		ICIAN: To the best of my know						use(a) and manner as stated.
BE	29b. SAGHATURE AND TYTLE OF CERCHELE		un t	10	29c. LICENSE NUI			NED (Minth, Day, Year)
T0	30. NAME AND ADDRESS OF PERSON WHO COR COR COR COR COR COR COR COR COR CO	O COMPLETED CAUSE OF DE	0 4000	Print)  5 AXVA	palis	ROAD	1, 1/1	20/ / [



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BA	The ATTENDING PHYSICIAN: The law requires that the death certificate he executed within 24 hours after dea
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DIVISION OF VITAL RECORDS, P.O. BOX 68760.	9
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	# HOSPITA
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21.21 BARCLAY ST.  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CITY  10. CIT	
JAMES JACOBS  4. SOCIAL SECURITY NUMBER  2. 18 - 28 - 8792  MID 2   F 63 YRS.  4. SOCIAL SECURITY NUMBER  2. 18 - 28 - 8792  MID 2   F 63 YRS.  4. SOCIAL SECURITY NUMBER  2. 18 - 28 - 8792  MID 2   F 63 YRS.  4. SOCIAL SECURITY NUMBER  2. 18 - 28 - 8792  MID 2   F 63 YRS.  4. SOCIAL SECURITY NUMBER  2. 18 - 28 - 8792  MID 2   F 63 YRS.  4. SOCIAL SECURITY NUMBER  2. 18 - 28 - 8792  MID 2   F 63 YRS.  4. SOCIAL SECURITY NUMBER  2. 18 - 28 - 8792  MID 2   F 63 YRS.  4. SOCIAL SECURITY NUMBER  2. SOCIAL SECURITY NUMBER  2. SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 21 18 ARCLAY ST.  RESIDENCE OF DECEDENT  MARYLIND  N/A  10 S. STATE  10 S. STATE  10 S. STATE  10 S. STATE  11 SAMATIAL STATUS  MARYLIND  N/A  11 SAMATIAL STATUS  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 28 1 19 31  SEPT. 29 1 19 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	3. TIME OF DEATH
218-28-8792 X M 2 F 63 YRS.  SEPT. 28,1931  Se. FACILITY NAME (# not institution, give street and number)  2121 BARCLAY ST.  RESIDENCE OF DECEDENT  106. STATE  106. COUNTY  MARYLND  N/A  106. STATE  106. COUNTY  MARYLND  N/A  106. STATE  106. COUNTY  MARYLND  N/A  106. STATE  106. COUNTY  MARYLND  N/A  106. STATE  106. CITY  106. CITY  106. CITY  106. CITY  106. CITY  106. CITY  106. CITY  106. CITY  106. CITY  106. CITY  106. CITY  107. ZIP CODE  21218  UNITE  11. MANIALISTATUS  N/A  11. MANIALISTATUS  N/A  12. WAS DECEDENT EVER IN U.S. ANMED  If YES, GIVE WAR OR DATES  11. WAS DECEDENT ON INSPANIC ORIGIN? (Specify Yee or No- If Yes, Specify Cubins, Massican, Puerto Ricen, stc)  11. WAS DECEDENT ON INSPANIC ORIGIN? (Specify Yee or No- If Yes, Specify Cubins, Massican, Puerto Ricen, stc)  12. WAS DECEDENT'S BUILD COUNTY  N/A  13. WAS DECEDENT'S USUAL OCCUPATION  (Specify or) Phylorider gives completed?  16. Decedent in the Manial or working in the Manial or working in the Norther's NAME (First, Middins, Last)  17. FATHER'S NAME (First, Middins, Last)  18. MOTHER'S NAME (First, Middins, Last)  19. INFORMANT'S NAME (Type-Print)  TYPONE JACOBS  19. INFORMANT'S NAME (Type-Print)  TYPONE JACOBS  19. INFORMANT'S NAME (Type-Print)  TYPONE JACOBS  19. INFORMANT'S NAME (Type-Print)  TYPONE JACOBS  19. INFORMANT'S NAME (Type-Print)  TYPONE JACOBS  19. INFORMANT'S NAME (Type-Print)  TYPONE JACOBS  19. INFORMANT'S NAME (Type-Print)  TYPONE JACOBS  19. INFORMANT'S NAME (Type-Print)  TYPONE JACOBS  19. INFORMANT'S NAME (Type-Print)  TYPONE JACOBS  19. INFORMANT'S NAME (Type-Print)  TYPONE JACOBS  19. INFORMANT'S NAME (Type-Print)  TYPONE JACOBS  19. INFORMANT'S NAME (Type-Print)  TYPONE JACOBS  19. INFORMANT'S NAME (Type-Print)  TYPONE JACOBS  19. INFORMANT'S NAME (Type-Print)  TYPONE JACOBS  19. INFORMANT'S NAME (Type-Print)  TYPONE JACOBS  19. INFORMANT'S NAME (Type-Print)  TYPONE JACOBS  19. INFORMANT'S NAME (Type-Print)  TYPONE JACOBS  19. INFORMANT'S NAME (Type-Print)  TYPONE JACOBS  19. INFORMANT'S NAME (Type-Pri	7:15P M
Be. FACILITY NAME (If not institution, give street end number)  Be. CITY, TOWN OR LOCATION OF DEATH  BALTO. CITY  N/A  TRESIDENCE OF DECEDENT  100. CITY  MARYLND  N/A  100. STREET AND NUMBER  2121  BARCLAY ST.  100. CITY  MARYLND  N/A  100. STREET AND NUMBER  2121  BARCLAY ST.  100. CITY  MARYLND  N/A  100. STREET AND NUMBER  2121  BARCLAY ST.  100. CITY  MARYLND  N/A  100. STREET AND NUMBER  2121  BARCLAY ST.  100. CITY  MARYLND  N/A  100. STREET AND NUMBER  2121  BARCLAY ST.  100. CITY  MARYLND  N/A  100. STREET AND NUMBER  2121  BARCLAY ST.  100. CITY  N/A  100. STREET AND NUMBER  2121  BARCLAY ST.  100. CITY  N/A  100. STREET AND NUMBER  2121  BARCLAY ST.  100. CITY  N/A  11. MARITAL STATUS  Were Warried 2   Married 3   Married 3   Married 3   Married 3   Married 3   Married 3   Married 3   Married 3   Married 3   Married 5   Married 3   Married 3   Married 5   Married 3   Married 5   Married 5   Married 5   Married 5   Married 5   Married 5   Married 5   Married 5   Married 5   Married 5   Married 5   Married 5   Married 5   Married 5   Married 5   Married 5   Married 5   Married 6   Married 6   Married 7   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Married 8   Marr	HPLACE (State or Foreign NORTH
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MARYLND N/A  BALTO. CITY  106. STREET AND NUMBER 2121 BARCLAY ST.  11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Vee or No- 14. RAC Blac Specify only injusted prote completed)  15. DECEDENT'S EDUCATION (Specify only injusted prote completed)  16. DECEDENT'S USUAL OCCUPATION (Specify only injusted prote completed)  16. MOTNER'S NAME (First, Middle, Maiden Sumame)  17. FATHER'S NAME (First, Middle, Last)  FIELD JACOBS  19. INFORMANT'S NAME (First, Middle, Maiden Sumame)  TYRONE JACOBS, SR.  2121 BARCLAY ST. BALTO, MD. 21.  22. NAME AND ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  23. PART I. Enter the diseases, or complications that Saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (First)  IMMEDIATE CAUSE (First)  IMMEDIATE CAUSE (First)  IMMEDIATE CAUSE (First)  IMMEDIATE CAUSE (First)  IMMEDIATE CAUSE (First)  IMMEDIATE CAUSE (First)  II. MARITAL STATUS  12. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Vee or No- I 14. RAC Blac II. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Vee or No- I 15. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Vee or No- I 14. RAC Blac I 15. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Vee or No- I 15. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Vee or No- I 14. RAC Blac I 15. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Vee or No- I 14. RAC Blac I 15. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Vee or No- I 15. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Vee or No- I 14. RAC Blac I 15. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Vee or No- I 14. RAC Blac I 15. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Vee or No- I 15. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Vee or No- I 15. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Vee or No- I 15. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Vee or No- I 15. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Vee or No- I 15. WAS DECENDENT OF NISPANIC ORIGIN? (Spec	
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Elementary/Secondary (0-12)  STH  N/A  VENDOR  16. MOTNER'S NAME (First, Middle, Melden Surmame)  MAMIE GRAY  190, INFORMANT'S NAME (Type/Print)  TYRONE JACOBS, SR.  200, MATOD OF Disposition  TYRONE JACOBS, SR.  201, INFORMANT'S NAME (Type/Print)  TYRONE JACOBS, SR.  2121 BARCLAY ST. BALTO, MD.  2122 BARCLAY ST. BALTO, MD.  2121 BARCLAY ST. BALTO, MD.  2121 SIGNATURE OF DISPOSITION (Name of competery, cremetory or other place)  WESTERN STAR  22. NAME AND ADDRESS OF FACILITY  CALVIN B. SCRUGGS FUNERAL  1412 E. PRESTON ST. BALTO,  IMMEDIATE CAUSE (Finst disease or condition)  IMMEDIATE CAUSE (Finst disease or condition)  MALIO ADADO  19. MOTHER'S NAME (First, Middle, Melden Surmame)  MAMIE GRAY  199. MAMIE GRAY  190. MAMIE GRAY  200. PLACE AND ADDRESS (Street and Number or Rural Poute Number, City or Town, Stete, Zip Code)  WESTERN STAR  220. NAME AND ADDRESS OF FACILITY  CALVIN B. SCRUGGS FUNERAL  1412 E. PRESTON ST. BALTO,  IMMEDIATE CAUSE (Finst disease or condition)  MALIO ADADO  10. MALIO ADADO  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAMIE GRAY  10. MAM	
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23. PART I. Enter the disesses, pr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition	
	Approximate Intervsi Between Onset and Death
resulting in death)  a	1 - 915
Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in desth) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):	
Cause, Enter UNDERLYING CAUSE (Disease or Injury	
CAUSE (Disease or Injury that initiated eventa resulting in desth) LAST	
d	
PART II. Other algorificant conditions contributing to desth but not resulting in the underlying cause given in Part I. 24e. Was AN AUTOPSY PERFORMED?	. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE
	OF DEATH?
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN	
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2 MEDICAL FAMINED On the beels of examination end/or investigation, in my opinion, death occured at the time, data and place, and due to the ceuse(c	a) end manner ee stated.
29c. LICENSE NUMBER 29d. DATE SIGNED	(Mprith, Day, Year)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	0 1
31. DATE FILED (MODELLE PORT) JULY STEELS (MODELLE PORT) JULY (1995) JULY STEELS (MODELLE PORT) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (1995) JULY (	( a



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BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page be filed within 72 hours after death with the State Deter, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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OR ATTENDI	DIRECTOR: A	tem 28 is
HOSPITAL	FUNERAL I	RTANT: If I
TO THE	THE De fied	IMPOF

DIVISION OF VITAL RECORDS, P.O. BOX 68760

N.A. Per Funeral Home STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Michael Dennis Kayanaugh APRIL 30 1995 12:26 A MICHAEL D. KAVANAUGH 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 216-04-3137 M 2 D 27 05-20-1967 MARYLAND 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR MD. RTE. 152&STONEY BROOK ROAD **FALLSTON** HARFORD RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE BALTIMORE MARYLAND 1 YES XX NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 21237 1-C MAIDSTONE COURT 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 1990-1994 11. MARITAL STATUS 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Married BY 1 TYES AND Specify: Specify: 3 Widowed 4 Divorced WHITE ETED 16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY life. Do NOT use retired. Elementary/Secondary (0-12) ENGINEER EQUIPMENT OPERATOR College (1-4 or 5+) U.S. MARINE CORPS. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) GEORGE DENNIS KAVANAUGH LOCKE CLAUDIA C. 196. MAILING ADDRESS (Street and Number of Rural Route Number, City of Town, State, Zip Code)
50. RATE CTECLE, HANOVER, PA. 17331 19a. INFORMANT'S NAME (Type/Print) 2 GEORGE DENNIS KAVANAUGH 50 BAIR CIRCLE, HANOVER, PA. 20s. METHOD OF DISPOSITION
1 A Burlai 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State 1995 VETERANS CEMETERY CROWNSVILLE, MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AODRESS OF FACILITY SINGLETON FUNERAL HOME, SECOND AVENUE, S.W. GLEN BURNIE, MARYLAND 21061 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch se cerdiec or respiratory arrest, shock, or heert failure. Liet only Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) ISEQUENCE OF): Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO JOR AS A CONSEQUENCE OF): thet initiated events reaulting in death) LAST PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🕍 UNCERTAIN 🗆 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 XYES 2 NO Inpetient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Residence 8 - Other (Specify) AT SCENE 27. MANNER OF DEATH 28e. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED IN COLUSION THE OF THE TO IN COLUSION THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF THE OF T 28b. TIME OF 28c. INJURY AT WORK? 12017 M 1 Natural
2 Accident
3 Suicide 4.30.95 28e. PLACE OF INJURY — At home, farm, street, building, etc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, Stele) 8 Could not be 4 Homicide determined Rh 152 + STONEY BEACK RD STREET 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of any knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) end manner as stated. 29b. SIGNATURE TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) APRIL 30,1995 O.C.M.E. LETED CAUSE OF DEATH JITEM 27) (Type, Print)

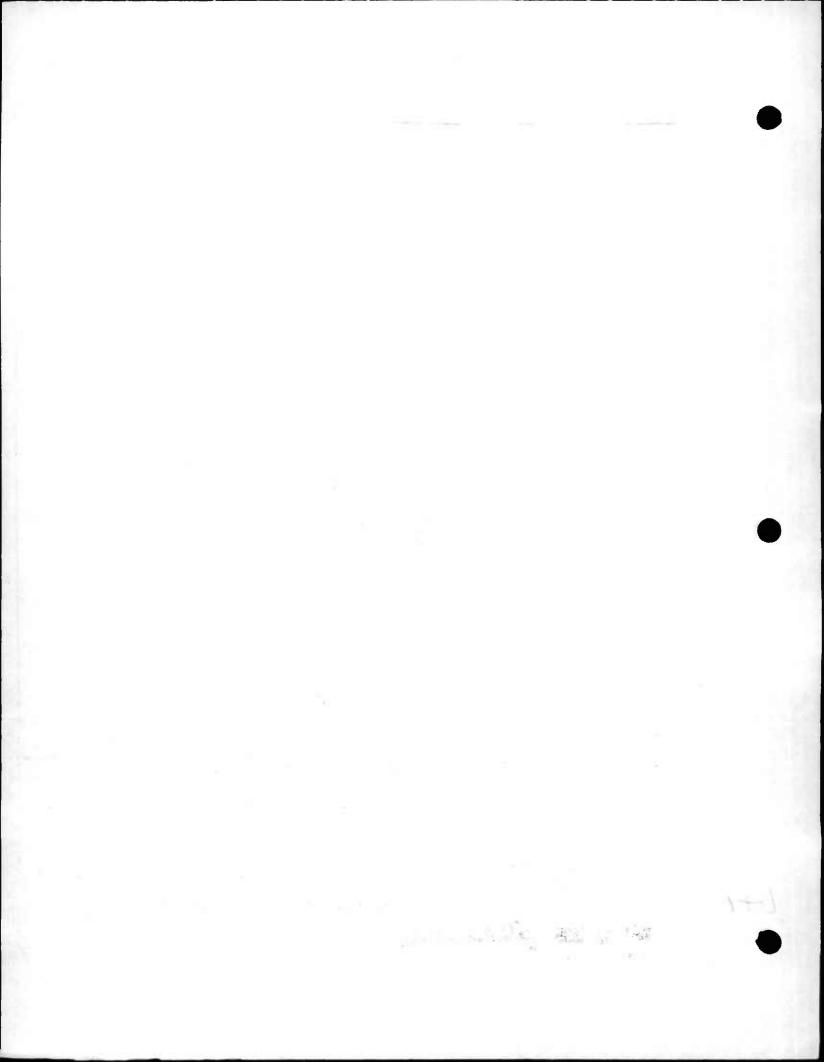
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32 REGISTRAR'S SIGNATURE

Devolor Rayfall

PENN STREET, BALTIMORE, MARYLAND 21201

DHMH-18 Rev 1/89



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68769

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the fours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ITEMS: 18. 19a, PER F.H. FILM G-723 5/2/95 t.t FOR STATE OF MADVI AND / DEDADTMENT OF HEALTH AND MENTAL HYGICAE

	1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO.												
	1. DECEDENT'S NAME (First, Middle, Lest)  2. DATE OF DEATN  3.										. TIME OF DEATH		
	BRONYA	OLODENKO	)			APRIL 29, 1995				3:00 A M			
			AGE (In yrs. lesi bi		IF UNDER 1 YE			7. DATE OF BIRTH				ACE (State or Foreign	
	218-39-8726	□ M 2 🗶 F	76	YRS.	MONTHS DA	rs HOURS	MIN.	OCT.	24,			SIA	
	9e. FACILITY NAME (If not institution, give stree				9b. CITY, TO	VN OR LOCATI	ON OF DE			_	TY OF DEA	TN	
DIRECTOR	10 RICHMAR RD, APT. E OWINGS MILLS BALTIMORE										RE		
	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY	1	Oc. CIT	, TOWN OR L	CATION						Od. INSIDE CITY		
8	MD BAT.T	IMORE				S MILL	S					LIMITS?  X YES 2 \( \square\) NO	
4	10e. STREET AND NUMBER				0.1.221	10g. CITIZEN OF							
E	10 RICHMAR RD, APT.E								SSIA				
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AF						IC ORIGIN? (Specify Yes or No- 1			-	- American Indian, White, etc.		
BY	1 Never Married 2 Merried FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES				If yo	, specify Cube YES 2 🙀 NO	n, Mexice Specify						
	3 Widowed 4 Divorced			- N- X						WHITE			
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con	npleted)	(Give i	CEDENT'S USUAL OCCUPATION ive kind of work done during most of working Do NOT use retired.)					OF BUS	SINESS/IND	USTRY		
12	Elementary/Secondary (0-12) (	College (1-4 or 5+)	100		EMAKER		AT HOME						
M	17. FATHER'S NAME (First, Middle, Last)						UEDIO NA						
	YOSEF KESELMAN  18. MOTNER'S NAME (First, Middle, Last)  YOSEF KESELMAN  18. MOTNER'S NAME (First, Middle, Melden Surname)  ZIATA  UNKNOWN												
BE	19e. INFORMANT'S NAME (Type/Print)		19b. M	AILINO	ADDRESS /St			Route Number, Ci			Codel		
2	DIMITRI KHOLODANKO	KHOLODENKO						OWING				1117	
	20a. METHOD OF DISPOSITION		20b. PLACE AND	DATE	F DISPOSITIO		T. 17	DATE			City or Town		
	1 Buriel 2 Cremetion 3 Remova 4 Donation 5 Other (Specify)	from State	ART.TNCT			NITING	) /	30-05	DAT	mTMO:	DE M	ID.	
i	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  ARI.INGTON—CHIZIIK AMINO 4-30-95 BAI.TIMORE. MD  22. NAME AND ADDRESS OF FACILITY  22. NAME AND ADDRESS OF FACILITY  23. NAME AND ADDRESS OF FACILITY												
	Mas VIV	SOL LEVINSON & BROS., INC.								WD 01015			
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest,  Approximate												
	shock) or heart feliure. List only one ceuee on each line.										interval Between Onset and Death		
	disease or condition	Bre	act i	CANO									
	disease or condition										3yrs		
Z	Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the American Constant of the Ameri												
CERTIFICATION	Sequentially list conditions, If any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):												
2	CAUSE (Disease or injury												
	that initiated evanta DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST												
8	are an action												
DICAL	PART II. Other significent conditions c	ontributing to de	ath but not resu	ilting i	the under	ying ceuse g	iven in i	Part I. 24a.		AUTOPSY		ERE AUTOPSY FINDINGS	
음	- Ver allan									OMPLETION OF CAUSE F DEATH?			
ME											□ YES 2 0 NO		
ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN												
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  HOSPITAL:  OTHER:												
PHYSICIAN:	1 YES 2 NO	1   Inpatient 2   ER/Outpatient 3   DOA   4   Nursing Home 5   Residence 6   Other (Specify)											
	1 Naturel 5 Pending	7. MANNER OF DEATN 200. DATE OF INJURY (Month, Day, Year)				INJURY AT WORK?	20d. DEŞCRIBE HOW INJURY OCCURED						
B	2 Accident Investigation				M 1 YES 2 NO				281 LOCATION (Company)				
9	3 Suicide 6 Could not be 4 Nomicide determined	(Specify)	iorin, s	ireet, rectory,	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
COMPLET													
MP	(Check only 1241 CERTIFYING PRYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es steled.												
8	2 MEDICAL EXAMINER: On the bests of examination and/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(s) end menner as stated.												
BE	296. SIGNATURE AND TITLE OF CERTIFIER	TTEMOING MD D240								RIGNED (Month, Day, Year)			
2	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CALISE	OF DEATH STEM		- 1	nb 024000				►APRIL 29, 1995			
	30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)  SIVAL HOSPITAL OF BALTIWORE, BALT. MD  31. DATE FILED (Month, Day, Year)  MAY 02 1995  July Date of Death (ITEM 27) (Type, Print)  AND  32. REGISTRAR'S SIGNATURE												
- 11	31. DATE FILED (Month, Day, Year)  A 32. REGISTRAR'S SIGNATURE												
, ii	MAY 02 1995	L 32. REGISTRAR'S	SIGNATURE										

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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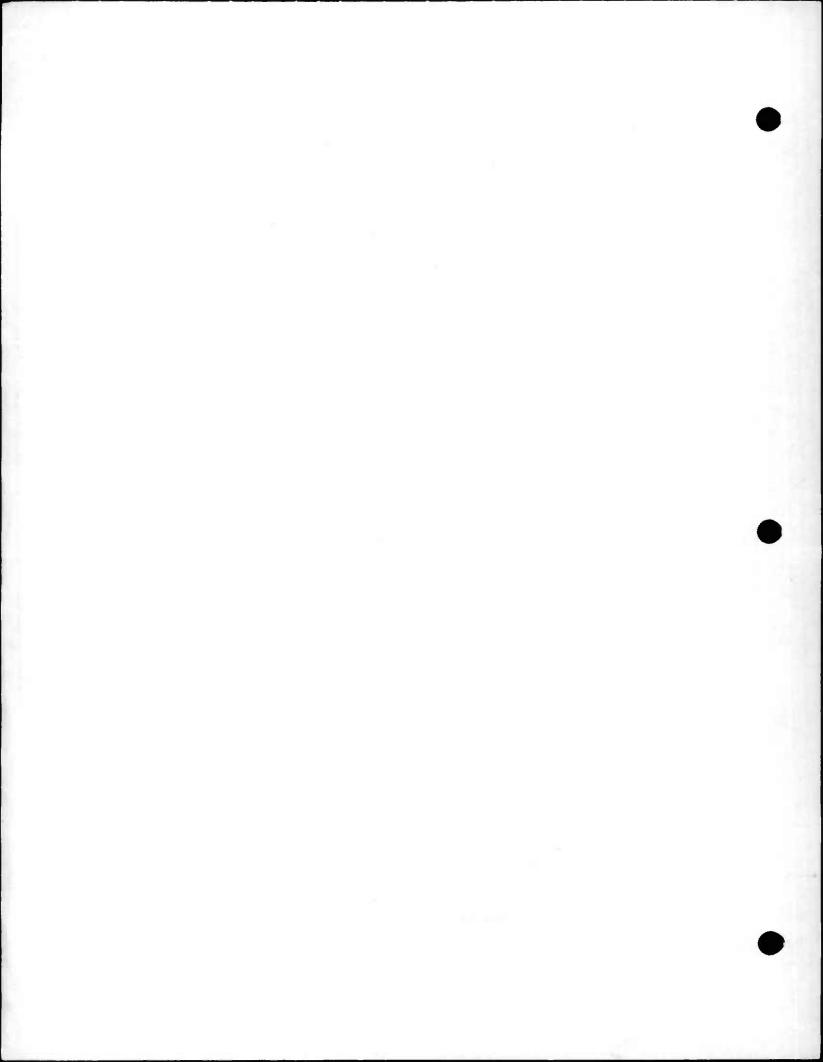
												95		3232	
	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE														
		REGISTRAR		С	ERTIF	ICAT	E OF	DEAT	ГН		REG. NO				
		1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATN MONTH DAY YEAR				3. TIME OF DEATH			
		4 SOCIAL SECURITY NUMBER				,		4 24-95				IDH M			
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	- 1	216-22-3008	1 M 2 G F	69	YRS.					APR	. 10,	1926	WASI	HINGTON, DO	
١,	.	la. FACILITY NAME (If not institution, give atreet and number)				9b. CITY, TOWN OR LOCATION OF DE						9c. COUNT			
Š	5	LAUREL REGIONAL				LA	AURE	L		PRINCE GEORGE					
DIRECTOR	3	RESIDENCE OF DECEDENT  10a, STATE  10b, COUNT	10c CIT	Y TOWN	OBLOCAT	ION	_					a diameter			
1 9		MARYLAND	MANTGONE	ONTGOMERY					I LVEI	D CD	DINC		- 1	10d. INSIDE CITY LIMITS?	
	- 10	10e. STREET AND NUMBER	MONTOUNE	K)			Line	ZIP CODI		X Sr	KING	40- 01717		t YES 2 NO	
FIINERAL			DAID #1/A	1								113		HAT COUNTRY?	
Z		9727 MT. PISGAH	12. WAS DECEDENT		20150	20903					USA				
		1 X Never Married 2 Married	FORCES? 1	YES 2			If yes, sp	ecity Cuba	n, Maxicai	n, Puerlo	GIN? (Specify Yea or No— 14. RACE — American Black, White, atc.)			- American Indian, White, atc.	
2		3 Wildowed 4 Divorced	IF YES, OIVE W	AR OR DATES		t YES 2 V NO Specify:					Specify: WHIT			WHITE	
ETED	3	15. DECEDENT'S EDU		18a. OE	CEDENT'S	USUAL C	CCUPATIO	ON		168	. KIND OF BU	SINESS/INDUS	STRY		
[		(Specify only highest grade Elamentary/Secondary (0-12)	e completed) College (1-4 or 5 +	100	ive kind of a. Do NOT us	work done se retired.)	during mo	st of workin	g						
.   5		12	0		STATI	ONAR	NARY ENGINEER STA					TE GOVERNMENT			
at once.		17. FATNER'S NAME (First, Middle, Last)						16. MOTE	NER'S NAI		Middle, Maiden				
6 II		BENJAMIN A KING.							OL	IVE	WARFIE	LD			
		19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	AOORES	S (Street a	nd Number					ode)		
TO BE	- 1	19a. INFORMANT'S NAME (Type/Print)  19b. MAILING AGORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  MARGARET M. ARGENT  723 BROOKWOOD ROAD, BALTIMORE, MARYLAND 21229													
	ı	206. METNOO OF DISPOSITION 200 PLACE AND DATE OF DISPOSITION (Name of													
		1   Burtal 2   Cramation 3   Ramoval from State   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Completon or charge place   Comple													
	Î	21. SHONATURE OF PUNETAL SERVICIOLICESSEE 22. NAME AND ADDRESS OF FACILITY FLECK FUNERAL HOME, INC													
a contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of	4	7601 SANDY SPRING ROAD, LAUREL, MD 20707													
-	⊣														
100		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ahock, or heart failure. List only one cause on each line.  Approximate interval Between													
2	IMMEDIATE CAUSE (Fine)										Onset and Death				
1,1	disease or condition resulting in deeth)  A ESPIKATORY FAILURE  DUE TO (OR AS A CONSEQUENCE OF):										6 wees.				
2															
	Sequentially list conditions,  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):											loyeas.			
ERTIFICATION	If any, leeding to immediate  Ceuse. Enter UNDERLYING														
		CAUSE (Disease or Injury & c. PCOIL HIRIAC FIBIC							166	AT	NON		6 weeks		
	that initieted events resulting in death) LAST									/					
ں اخ		resulting in death) LAST d. CONCIESTIVE HEART FAILURE. Gures.													
OICAL		PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS													
MEDICAL												COMPLETION OF CAUSE			
휘벌	1	//													
		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐													
NA NA		25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one)													
PHYSICIAN:		EXAMINER?  1 YES 20 NO  HOSPITAL:  1 YES 20 NO  OTHER:  4   Nursing Nome 5   Residence 6   Other (Specify)													
PH (3.		27. MANNER OF DEATH	28a. DATE OF	INJURY	28b. TIM	E OF	28c. INJI	URY AT	alderica (		CRIBE NOW II	NJURY OCCU	RED		
		Natural 5 Pending	(Month, Da	(Month, Day, Year) INJURY V			1   Y	WORK?							
BY 8		3 Suleide	28s. PLACE OF	28s. PLACE OF INJURY — At home, larm, street, factory, office						281. LOCATION (Street and Number or Rural Route Number,					
	4 Nomicide determined building, etc. (Specify)  building, etc. (Specify)  building, etc. (Specify)  building, etc. (Specify)														
COMPLETED	1	29a. CERTIFIER (Check only)  CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.													
MP															
8	-	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the lime, data and placa, and due to the cause(a) and manner as stated.													
BE		29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)									fonth, Day, Year)				
2		20 NAME AND ADDRESS OF STREET	W.					D	36	68		- 4	-24	1-95	
1	- 11	30. NAME AND ADDRESS OF PERSON WN	IU COMPLETED CAUS	E OF DEATH /ITE	M 27) /Time	Prints									

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

AZHER HUSSAIN TO ABIT, EDGE WCCD RD

31. NAME SILER (Nym1993 Jun)

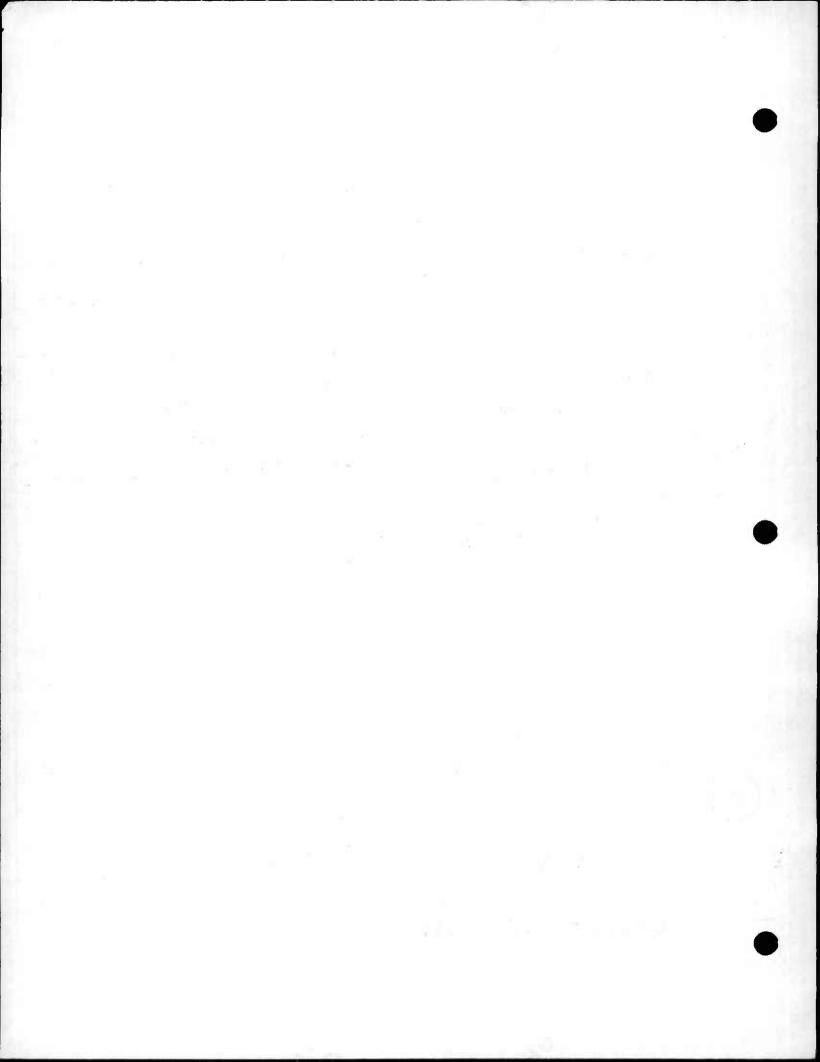
COLLEGE PARK ID



1 - FOR STATE REGISTRAR

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		1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ND / DEPARTM			MENTA	HYGIENE REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last) SALLY			2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH 8:42AM						
P		4. SOCIAL SECURITY NUMBER 205-09-9743	1 M 2 TF	86 YRS. MOI	UNDER 1 YEAR OTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	DEC.	OF BIRTH , Day, Year) 14,19		Country)	SYT.VANTA
E, MARYLAND 21215-0020  y be retained by the hospital or attending physician.  bage 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be notified at once.	TOR	99. FACILITY NAME (If not institution, give sti MERIDIAN NURSING RESIDENCE OF DECEDENT		96	TOWS	ON LOCATION OF D	PEATH		9c. COUNTY BA	OF OEAT	
	DIRECTOR	100. STATE 10b. COUNTY MARYLAND	N/A	10c. CITY, TO	WN OR LOCAT					d. INSIDE CITY LIMITS? J YES 2 NO	
	FUNERAL	6309 WIRT AVE.				21215			10g. CITIZEN	OF WHA	T COUNTRY?
	B≺	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE		If yes, spi	ENDENT OF HISPA ecify Cuben, Mexic 2 NO Speci	en, Puerto F	? (Specify Yee o		RACE — Black, W Specify:	American Indian, hite, etc.
	LETED	15. OECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)		AL OCCUPATIO done during mo- lired.)		16b.	KIND OF BUSI	BUSINESS/INDUSTRY			
	E COMPL	17. FATHER'S NAME (First, Middle, Last) ABRAHAM	BARISC	TH .	TEACH	ER 18. MOTHER'S NA ET	AME (First, A	DICATION SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATU			SILVER
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ALTIMORE, beath. Page 6 may be funeral director, page xaminer must be		20e. METHOO OF DISPOSITION  1 X Buriel 2 Cremetion 3 Remer  4 Donation 5 Other (Specify)	from State ADA	THE YESHUE	KUN	4-3		5 BALT			Stata
0 = 0		Againer L. A	tellman		6010		STOWN	ROAD I	BALTIN		MD 2121
withher hours withher hours pletely filled in the cremation, or referent, the medient,		23. PART I. Enter the disease, or contained, or heart failure. L. IMMEDIATE CAUSE (Pinal disease or condition resulting in death)	DIPPLICATIONS THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF THE COURSE OF TH	n ilne.							Approximete interval Between Onset and Death
OX 68 be execute clan and clor to buris raumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	OUE TO (OR AS A CO								
DS, P. the death c the attendi d Mental Hy Injury, or	CAL CERT	PART II. Other significent conditions		not resulting in th	e underlying	cause given in	Part I.	24a. WAS AN AL			RE AUTOPSY FINDINGS
RECC Heppins to Men signer of Health Shows at	MEDI	Thyrotoxicon		DEATH VEC		LINICEDTAL	_	1 TYES 2		OF	WPLETION OF CAUSE DEATH? YES 2 NO
TAL The law the Nest time Dept	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		PLACE OF DEATH (C	heck only one)						
N OF VI	>	27. MANNER OF DEATH  1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJL WOI M 1 TY	RK?		(Specify)	URY OCCUR	D	
VISIO	TED B	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — building, etc. (Specify)	At home, ferm, street	, fectory, office		281. LOCA City o	TION (Street and r Town, State)	d Number or F	lural Floute	Number,
2 2 E IZ	COMPLE		EIAN: To the best of my knowleds: On the basis of examination or							use(s) en	I menner es stated,
TO THE HOSPI TO THE FUNER be filed within	O BE C	286 SHOWATURE AND TITLE OF CERTIFIER		~ws		29c. LICENSE NU		1	Pad. DATE SIG	NED (Mo	nth, Day, Year)
2	Ĭ	30. NAME AND ADDRESS PERSON WHO CHESTING J	A	FERM		d. u			21093 D. LU	)	VILLE, MD
		31. DATE FILED (Month, Day, 16ar) MAY 0 2 1995 Ja	32. REGISTRAR'S SIGNATU	JRE LL			*				



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DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	ed in by the funeral director, page 5 should be detached for use as the burial-transit or removal.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withher of hours after death. Page 6 may be retained by the hospital or attending physician.	F FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit within 72 hours after death with the State Dept. of Health and Mental Hydiene prior to burial, cremation, or removal.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	_	HEGISTHAM		C	EKIIFI	CALE	OF DEATH	REG. NO				
		1. DECEDENT'S NAME (First, Middle, Last)  Elizabeth	ELNO.	RA	) /	411	EBE	2. DATE OF DEATH MONTH D.		YEAR 995 1611 D M		
		4. SOCIAL SECURITY NUMBER			st birthday)	IF UNDER 1 YE		7. DATE OF BIRTH	7 (	8. BIRTHPLACE (State or Foreign		
		177-09-9650	1 🗆 M 2 😿 F	76	YRS.	MONTHS DV	YS HOURS MIN.	(Month, Day, Year)	118	Country) Pennsylvania		
		June18, 1918 Pe								ITY OF DEATH		
2000 C 's 's color	OR	THE CINION ME	MODIAL HU	SAI	TAL	BI	BLTIMOR.	E CITY				
		RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY	Y		10c CITY	TOWN OR L	OCATION			Lead Ministration		
	DIRECTOR	Maryland								10d. INSIDE CITY LIMITS?		
		10a. STREET AND NUMBER			1 1	<u>Baltin</u>	101. ZIP CODE		10a, CITIZ	1 → YES 2 NO ZEN OF WHAT COUNTRY?		
	ER/	2902 Dunmore Street 21222 U.S.A.										
	FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. AI	RMEO	13. WAS	DECENDENT OF HISPAI	NIC ORIGIN? (Specify Yes		14. RACE — American Indian		
	ВУ	1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR		NO		s, specify Cuben, Mexico YES 2 NO Specif			Black, White, etc. Specify:		
	ED E	15. DECEDENT'S EDU	CATION	160 00	ECEDENT'S U	101111 00011	PATION	T	1	White		
	ETE	(Specify only highest grade Elementary/Secondary (0-12)	completed)  College (1-4 or 5+)	(0	Bive kind of wo	ork done durin	g most of working	16b. KIND OF BUS	SINESS/IND	JSTRY		
	PL	1.2	omemal	cer		Domest	ic					
once	COMPLET	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First, Middle, Maiden				
क्र	BEC		John E. Wise				He1	en Potter				
notified	0	19e. INFORMANT'S NAME (Type/Print)			b. MAILING	ADDRESS (St		Route Number, City or Tow	n, State, Zip	Code)		
be no	-	Dianne Turpin			P.O. I	30x 18	2 Bettert	on, Marylan	d 216	510		
		20a, METHOD OF DISPOSITION 1 → Burlet 2 □ Cremetion 3 □ Rem			AND DATE OF		N (Name of			City or Town, State		
=		4th Donation 8 th Other (Specify) New Goshenhoppen Cemetery 5/2 East Greenville, PA.										
i. examiner must		21. SIGNATURE OF FUNERAL SERVICE LICENSEE "22. NAME AND ADDRESS OF FACILITY										
val.		MARZULIO FUNGRAL SERVICE HOPERCO, Maryla										
or removal.		23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximata										
the m		IMMEDIATE CAUSE (Finel Onset and Death										
nt, th		disease or condition										
and Mental Hygiene prior to bunal, cremation, y Injury, or other traumatic event, the												
giene prior to buria other traumatic	8	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):    Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):										
traur t	CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury That initiated events  DUE TO (OR AS A CONSEQUENCE OF):  U.G.  DUE TO (OR AS A CONSEQUENCE OF):										
ther	Ē	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS	A CONSE	OUENCE OF		070			lucele		
Or O		resulting in death) LAST	d									
th and Menta any Injury,	-											
and In	MEDICAL		MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE								
Health Ws an		1 VES 2 TONO COMPL										
sho i		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
state Dept. of r Item 23 sho	IAN	25. WAS CASE REFERRED TO MEDICAL	MIDDIE TO CAUSE		CE OF DEATH							
r ite	Sic	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ☐ ER/Ou	Spatient 3		OTHER:	Home 5 - Reeldence	8 Other (Specify)				
d, or	PHYSICIAN:	27. MANNER OF OEATH	28e. DATE OF INJURY (Month, Day, Year)		28b. TIME INJU	OF 28c	INJURY AT WORK?	28d. DESCRIBE HOW II	NJURY OCC	URED		
death with s marked,	ВУ	1 Natural 5 Pending 2 Accident Investigation	nla				YES 2 NO					
ls n		3 Suicide 8 Could not be	28e. PLACE OF INJUF building, etc. (Sp	ty At ho	ome, farm, str	eet, factory,	offica	28f. LOCATION (Street a City or Town, State)	CCATION (Street and Number or Rural Route Number,			
tern 28 l	ETE	4 Homicide determined										
2 hours	립		CIAN: To the best of my kno	wledge, de	ath occurred	at the time,	date and piece, end due	to the ceuse(s) and man	ner ee atate	d.		
thin 7	COMPL	2 MEDICAL EXAMINE	R: On the basis of examinati	on end/or	investigation,	In my opinio	on, death occured at the	time, data end place, en	d due to the	ceuse(e) end manner es stated.		
or wi	ш	29b. SIGNATURE AND TITLE OF CERTIFIER	5 00 0				29c. LICENSE NUM		29d. DATE	SIGNED (Month, Day, Year)		
be filed within 72 I	0 8	No ordella	there &	7.8	-		2438	946-A9	<b>&gt;</b> 4	129/95		
	-	30. NAME AND ADDRESS OF PERSON WHI	D COMPLETED GAUSE OF D	EATH (ITE	M 27) (Type, F	Print)	0					
) [		ELEONORA CORDO	-LLA-MIEL	E,H	۵.	MHH	2016. UN	IV. PKWAY	1- P3/	4 UTHORE MB		
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<b>BALTIMORE</b> ,	Done
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the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. CHONG PHYSICIAN: The law requires that the death certificate be executed with

**USION OF VITAL RECORDS, P.O. BOX 68760** 

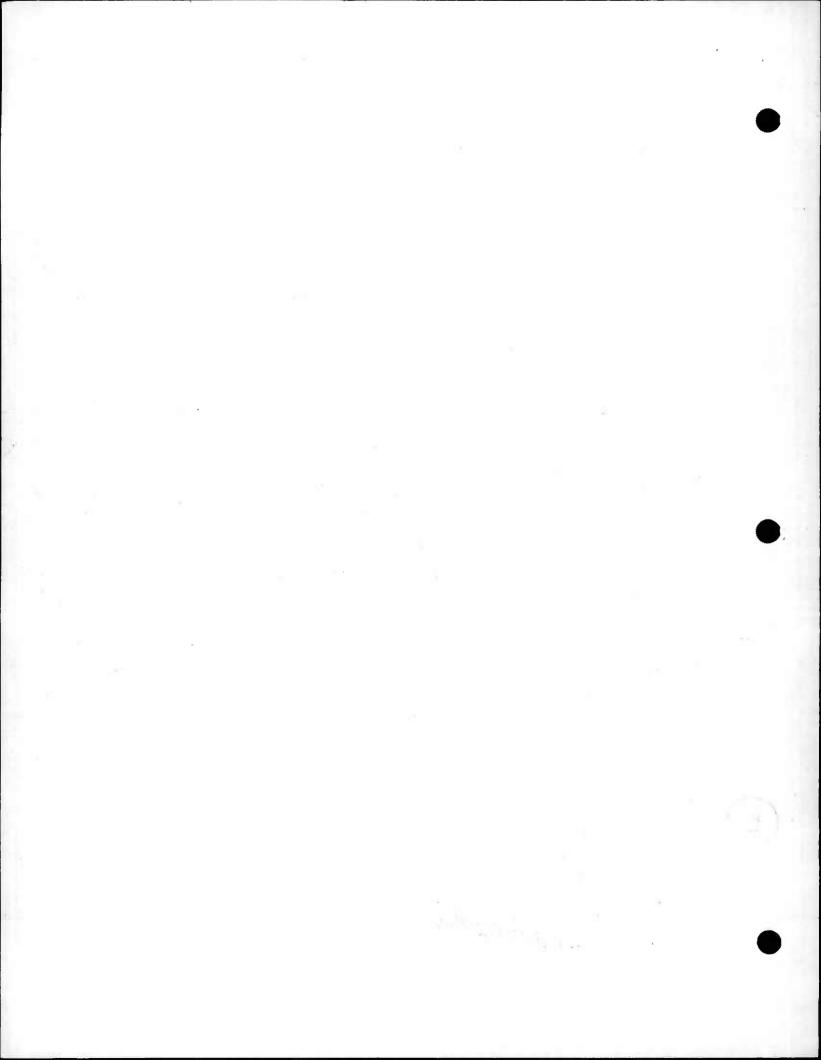
•											(	95	1323	5
	1 - STATE REGISTRAR	STATE OF N	MARYLAND /				EALTH .		MENTA	L HYGIEN				
1. DECEDENT'S NAME (First, Middle, Last)  2. DATE OF DEATH  3. TIME											3. TIME OF DEATH			
	Paul Thomas		CD						Apri			1995	9:38	a M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	it birthday)		ER 1 YEAR	IF UNDER	0.111101	7. DATE	OF BIRTN h, Day, Ybar)	,,,	8. BIRTH	PLACE (State or Foreig	gn n
	216-01-2180	1 XXM 2 □ F	82	YRS.	MONTHS	DAYS	HOURS	MIN.		11. ]	1913	Country	rvland	
	9a. FACILITY NAME (If not institution, give st	reet and number)			9b. CIT	Y, TOWN O	R LOCATIO	ON OF DE		9c. COUNTY OF DEATH				
DIRECTOR	Franklin Square H	ospital	tal Rossville Baltimore (								o County			
5	RESIDENCE OF DECEDENT  10e. STATE 10b. COUNTY			I 40 - 0/7	V 700101						Dari	TIIIOI		
	355 1100			10c. Cit		OR LOCAT		_					10d. INSIDE CITY LIMITS?	
									1 TES X NO	)				
<b>₹</b>	10009 Van Winkle	Lone				107.		220					HAT COUNTRY?	
FUNERAL	11. MARITAL STATUS		IT EVER IN U.S. AR									USA		
	1 Never Merried 2 Merried	FORCES? 1	YES XX		13	It yes, spe	city Cuban	. Maxice	n. Puerto	i? (Specify Yes Ricen, etc.)	or No-	14. RACE Black	- American Indian, White, etc.	
B	3 Widowed 4 Divorced	IF YES, OIVE W	AR OR DATES			1 TYES	2 X NO	Specify	y:	Spec			WHITE	
COMPLETED	15, DECEDENT'S EDUC (Specify only highest grade)								16b	KIND OF BUS	SINESS/INC	DUSTRY	741212	
ΙЩ	Elementary/Secondary (0-12)	College (1-4 or 5 +	- Hita	Do NOT us	work done se retired.	during mos	st of working	9						
4	12 vrs.	N/A	Re	etire	d Ca	otai	n		Ва	lto Ci	tv P	olice	e Dept.	
Ö	17. FATHER'S NAME (First, Middle, Last)							ER'S NA		Middle, Maiden				
BE	Vincent King						Mary	v Ho	11					
10	19s. INFORMANT'S NAME (Type/Print)		19(	b. MAJLING	AODRES	SS (Street a				ber, City or Town	n, State, Zip	Code)		
	Eloise King		1	.0009	Var	Win	kle L	ane	Bal	timore	, Md	. 212	220	
	20e. METHOD OF DISPOSITION  1)(XBuriel 2 Cremetion 3 Remo	oval from State	20b. PLACE A cemetery, cre	matani or of	that plans	d			DAT			City or Tov		
	4 Donation 5 Other (Specify)		- Garde	ens o	f Fa	ith	Cemet	tery	5-1	-95 Ba	ltim	ore,	Md.	
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE					D ADDRES							
	hhatha the	Aroth			!	LASSAH	N FUNE	ERAL	HOME,	INC. IMORE,	MADVI /	MD 21	226	i
	23. PART I. Enter the diseases, or co	omplications the	t caused the de	sth. Do r	ot ente	r tha mod	de of dyln	ng, auci	h ss csr	lac or reapi	ratory an	rest.	Approximate	
	shock, or heart fallure. L	List only ons csu	se on sach line	t.							socily to	12112	Onset and De	reen
	disesse or condition	Acuto	Uomowah											
	resulting in death)	DUE TO	Hemorrha (OR AS A CONSEC	TRE OI	F):								7 hours	}
z		Ruptur	ed Abdor	minal	Δο:	rtic	Anous	ruon	n				7 hours	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	OR AS A CONSEC	DUENCE OF	F):	<u> </u>	Alleu	r y.s.ı	1				/ nours	-
8	cause. Enter UNDERLYING CAUSE (Disease or Injury	£												
트	that initiated events	DUE TO	(OR AS A CONSEC	DUENCE OF	ን:									
1111	resulting in deeth) LAST	1												
	PART II. Other significant conditions	s contributing to	death but not r	eeulting !	n the u	nderlying	cause of	Ivan In	Part I.	24a, WAS AN	AUTOPSY	24b	WERE AUTOPSY FINOIR	NGS
MEDICAL	88								81	PERFOR	MEO?		AMILABLE PRIOR TO COMPLETION OF CAUS	77
0									-	1 TYES 2	X NO		OF DEATH?	-
	DID TOBACCO USE CONTR	PIRLITE TO CA	LISE OF DEA	TLI VE	s 🗆	NO E	UNCE	EDTAIN					1 TES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	IDOIL TO CA		E OF DEAT			UNCE	CKIAII	<b>ч</b> Ц					
Sic	EXAMINER? 1 ☐ YES 2 ☑ NO	HOSPITAL:	FR/Outpetient 3	□ DOA	OTHE				- C 4:					$\dashv$
Ξ	27. MANNER OF DEATH	28e. DATE OF	INJURY	28b. TIME		28c. INJL	JRY AT	Idence	_	CRIBE HOW II	NJURY OCC	CURFO		
	1 Natural 5 Pending	(Month, Di	ay, Year)	INJ	URY	1 D Y	RK?	NO						
Э ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE O	F INJURY — At ho	me, farm, s	street, fac	tory, office		-		ATION (Street a	nd Number	or Rural Ro	oute Number,	- 3
	4 Nomicide determined	ouliding,	etc. (Specify)						City	or Town, State)			P.	100
COMPLETED	29e. CERTIFIER (Check only 1 🔀 CERTIFYING PNYSIC	CIAN: To the heat of	my knowledge de	ath accura	of at the	400	and also		4-14	4	500 30			$\dashv$
₩	(Check only one) 2 MEDICAL EXAMINER													
	29b. SIGNATURE AND TITLE OF CERTIFIER		4		,,	,				One parent and				
핆	6/2 1/2/4/	0000	Kuch.	*			29c. LICEN						(Month, Day, Year)	
유	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CALL	PE OF OFATH ITTE	U 27) (%	Dalas*		K I	D 18	90		A	pril	27, 1995	

vili, M.D. 9000 Franklin Square Drive.

Vladimir Kakitelashvili,

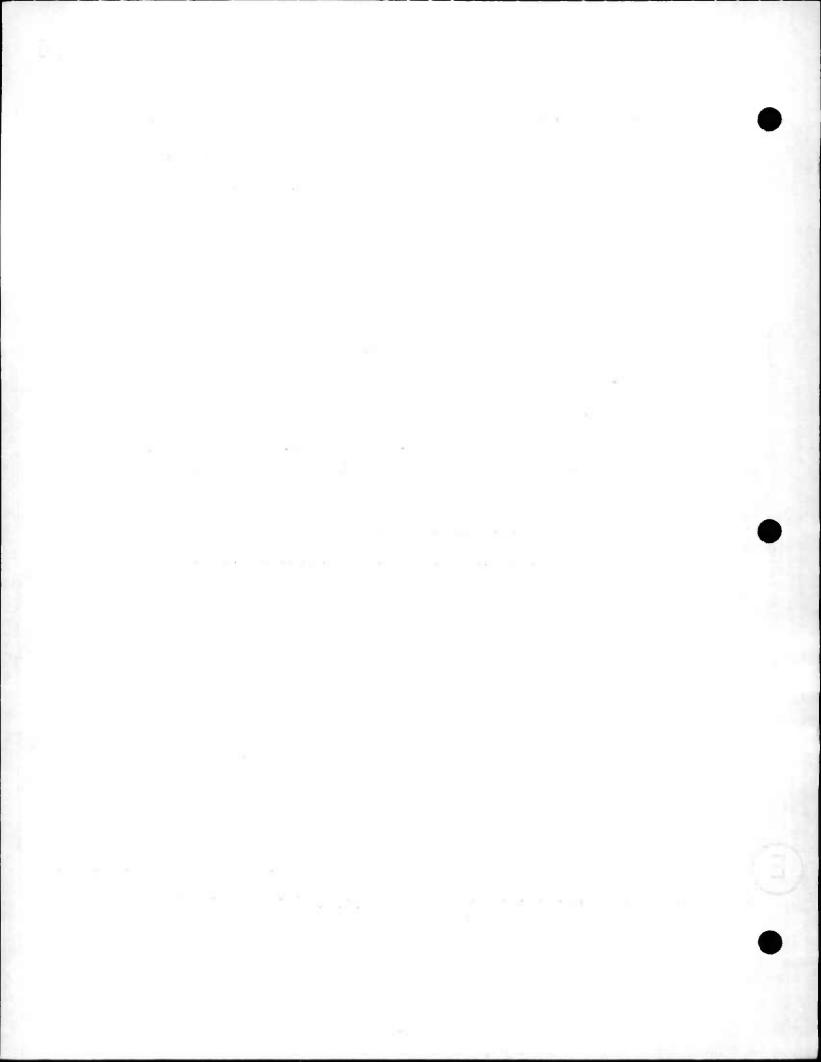
31. DATE FILED (Month, Day, Year)
MAY 0 2 1995

Baltimore.



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	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPARTI CERTIFIC	MENT OF	HEALTH AND I		GIENE G. NO.			
1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DE	ATH	3. TIME OF DEA		
N.	MARY ELVI	RA KRAM				04	27 19	95 8:27		
	4. SOCIAL SECURITY NUMBER			UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIR (Month, Day,	Manr)	BIRTHPLACE (State or F Country)		
ş	182 38 6628  9a. FACILITY NAME (If not institution, give	1 🗆 M 2 🗽 F	86 YRS.			April	18,190	9 Pennsyl		
Œ	Fort Washingto				OR LOCATION OF DE			TY OF DEATH		
16	RESIDENCE OF DECEDENT	n nospital		FOIT	Washing	ton	Prin	ce George		
DIRECTOR	10a. STATE 10b. COUNT			OWN OR LOCA				10d. INSIDE CIT		
		ce Georges	Fort		ington			1 TES 2		
FUNERAL	10e. STREET AND NUMBER	0		1 "	of, ZIP CODE		10g. CITIZE	EN OF WHAT COUNTRY?		
INE	601 Piscataway	12. WAS DECEDENT EVER	MI 14 D. A STATE		20744		USA			
8	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 NO	If yes, s	CENDENT OF HISPAN pecify Cuban, Mexica S 2 NO Specify	n, Puerto Rican, e	rtc.)	4. RACE — American Ind Black, White, atc. Specify: White		
ED	15. DECEDENT'S EDI (Specify only highest grad	JCATION e completed)	16a. DECEDENT'S US (Give kind of work	UAL OCCUPATI	ION cost of working	16b. KIND	OF BUSINESS/INDU			
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use n	etired.)	ost or working					
COMPLET	12		Homemake	er		Own	Home			
	17. FATHER'S NAME (First, Middle, Lest)	7			18. MOTHER'S NA		Maiden Surname)			
BE	Henry R. Wesse	1			Mary (					
10	Patricia A. Pr	athor			and Number or Rural I	Route Number, City	or Town, State, Zip C	Code)		
	20a. METHOD OF DISPOSITION		b. PLACE AND DATE OF C		0 above	0.75	no LOCATION OF			
	1 XBuriel 2 Cremetion 3 Ren 4 Donation 5 Other (Specify)	noval from Stata	metery, crematory or other	place)	Com 5/			ty or Town, State ersailles		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE A 22. NAME AND ADDRESS OF FACILITY									
	Ives-Pearson Funeral Homes									
_	Arlington VA 22201  26. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, Approximate									
	interval Betwee									
	IMMEDIATE CAUSE (Final disease or condition									
	reaulting in death)	DUE TO (OR AS A CONSEQUENCE OF):								
z	Sequentielly list conditions, If any, leading to immediate  b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE  DUE TO (OR AS A CONSEQUENCE OF):									
5										
S	CAUSE (Disease or injury									
TIF	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST									
CERTIFICATION		d								
CAL	PART II. Other aignificant condition	na contributing to death i	contributing to death but not resulting in the underlying ceuse given in Part					24b. WERE AUTOPSY F		
DIC			PERFORMED?  1   YES 2   NO		AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?					
MEDIC										
Ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH (	Check only one) THER:						
IYS	1 YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Out	patient 3 DOA 4	☐ Nursing Hon	ne 5 🗆 Residence					
	1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	WC	JURY AT ORK? YES 2 NO	28d. DESCRIBE	HOW INJURY OCCU	RED		
BY	2 Accident Investigation	28e. PLACE OF INJURY	Y — A1 home, 1arm, atres		111.	281 LOCATION (	Street and Munhas as	Don't Book Mark		
	3 Suicité à Could not be determined 28e. PLACE OF INJURY — A1 home, 1erm, street, 1ectory, office building, etc. (Specify)  28e. PLACE OF INJURY — A1 home, 1erm, street, 1ectory, office City or Town, State)  281. LOCATION (Street and Number or Rural ReCity or Town, State)									
٣	29a. CERTIFIER 1 TO CERTIFYING PHYS	ICIAN: To the best of my know	wladge double conversed of	t the time date						
COMPLETED	(Check only one) 2 MEDICAL EXAMINE							cause(s) and menner se s		
	296. SIGNATURE AND TITLE OF CENTIFIE				29c. LICENSE NUM		T			
8	1,	all.	mD			DER		SIGNED (Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WI	The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon		7()	D44916		I APR	RIL 28, 1		
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	31. DATE FILED (Month, Day, Year) MAY U 2 1995	2) REGISTRAPS GO	AUL.	,			,			
	MAY 0 2 1995									



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Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

95 13237 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Seonge YEAR Laub e ma 300 A H 195 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign 219-074029 1 M 2 - F M 25 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Swar Huntay Batimore DIRECTOR Bultimore Gity 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION Maryland Carroll County Westminster 1 YES 2 NO FUNERAL 10e STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3503 Oxwed Court 21157 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1X YES 2 NO IF YES, OIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC DRIGIN? (Specify Yea or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 □ YES 2 ☒ NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married BY 3 Widowed 4 Divorced Specify: WWII White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Manager Grocery Store 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) BE George L. Laube, Sr. Vivian T. Parks 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2 3503 Oxwed Court Westminster, MD 21157 Ms. Helen L. Mitchell e 20a. METHOD OF DISPOSITION
1 X Burlal 2 ☐ Cremation 3 ☐ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must woodlawn Cemetery

Woodlawn Cemetery 4 ☐ Donation 6 ☐ Other (Specify) _ 5/4/95 Baltimore, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY brian L. Haight HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400 medical 23. PART i. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiac or reepiratory arrest, Approximata ahock, or heart failure. Liet only one ceuse on each line. interval Betwe **IMMEDIATE CAUSE (Final Onaat and Death** the disease or condition Prostate CA > launte metastatic reaulting in death) event, DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditione, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE MEDICAL 1 YES 2 NO OF DEATH? 1 TES 2 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) OTHER: Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nt ursing Nome 5 - Residence 8 - Other (Specify) 6 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED Natural 2 Accident 5 Pending investigation 1 YES 2 NO М BY 26s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 8 Could not be 4 Nomicide 29a. CERTIFIER (Check only one)

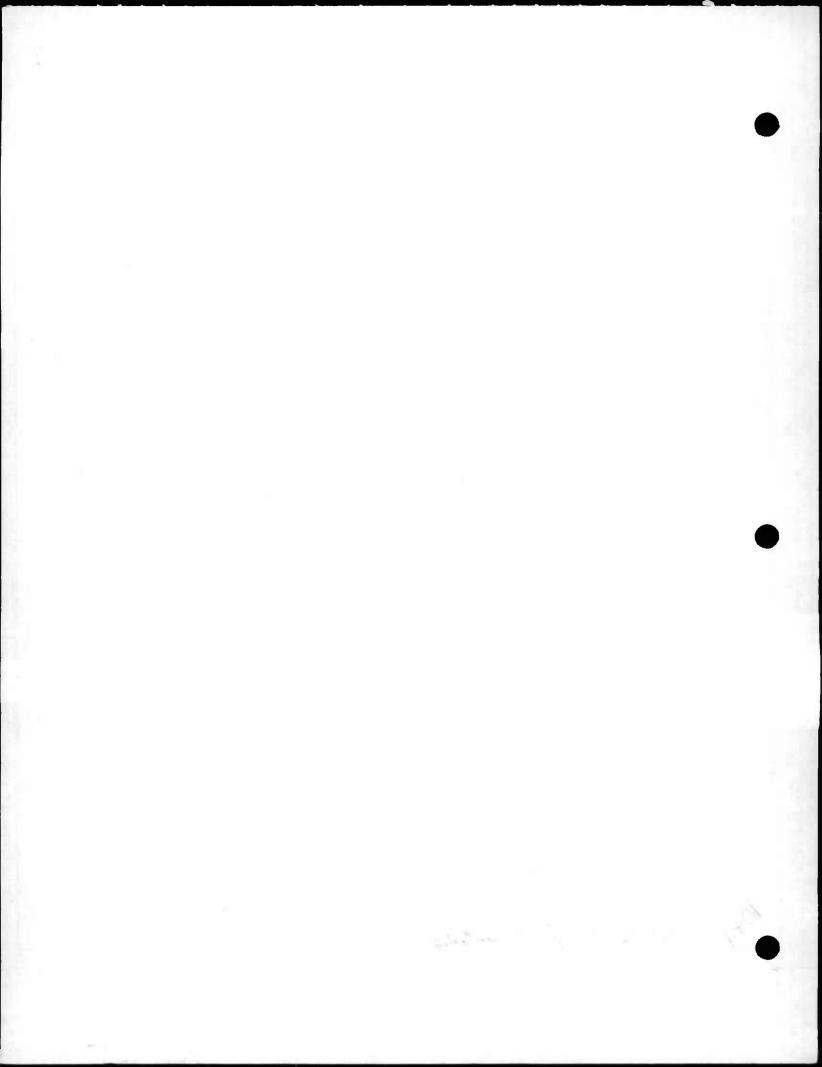
CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as stated.

MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER VL983 29d. DATE SIGNED (Month, Day, Year) BE

Hospital

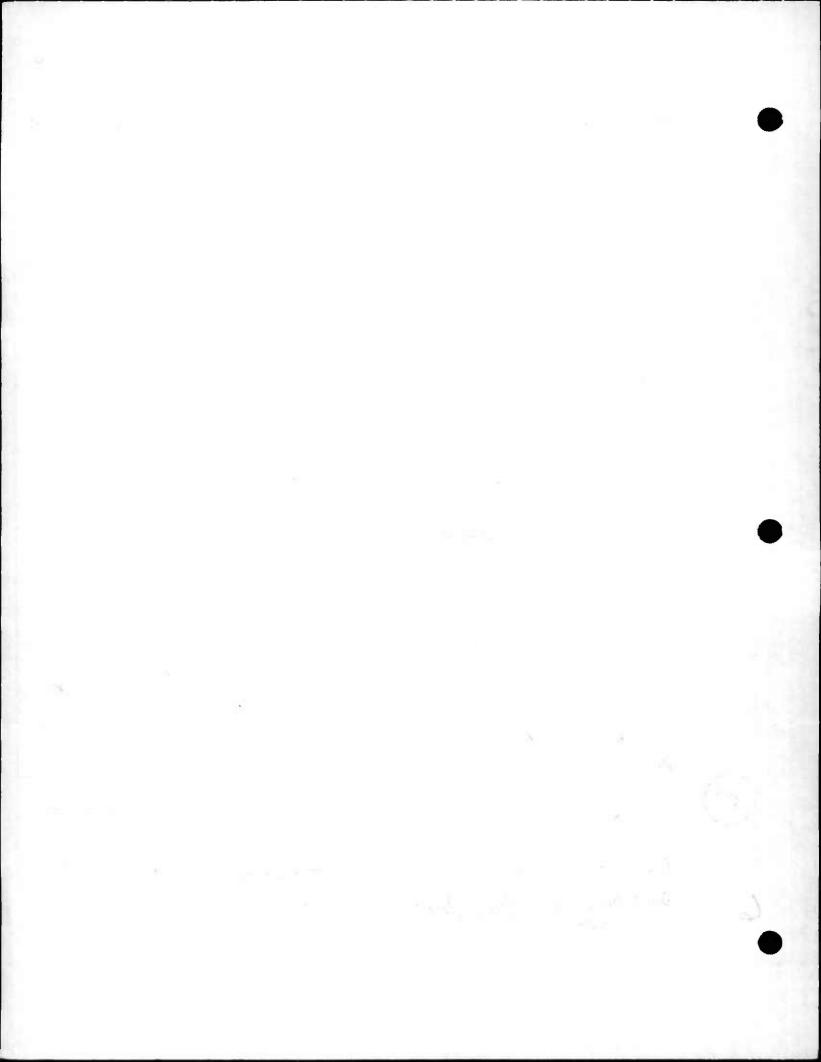
30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) MAY 0 2 1995

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		1 - STATE OF MARYLAND / DEPARTMENT OF CERTIFICATE O		MENTAL HYGIEN	E					
		1. DECEDENT'S NAME (First, Middle, Last) LIVING Lewen		2. DATE OF DEATH DA		3. TIME OF OEATH				
should		4. SOCIAL SECURITY NUMBER  5. SEX  101-09-6334  1  M 2  F	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)  JAN 15,19	911 NE	W YORK				
1, 2, 3	стов	GT111 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110 - 110	N OR LOCATION OF DEA	ATH	9c. COUNTY OF	DEATH				
nit. Pages	DIRE	MARYLAND N/A BAL'	CATION TIMORE			10d. INSIDE CITY LIMITS? 1 YES 2 NO				
an. ransit permit.	FUNERAL	3041 FALLSTAFF RD, APT. 502	101. ZIP CODE 21209	)	10g. CITIZEN OF	WHAT COUNTRY?				
215-0020 attending physician. se as the burial-transit	BY	1 Never Married 2 Married FORCES? 1 YES 2 ZNO If yes,	Specify Cuban, Mexican ES 2 NO Specify:	C ORIGIN? (Specify Yea , Puerto Rican, etc.)	Ble	CE — American Indian, ck, White, etc. celly: WHITE				
D 2121 spital or atte ed for use a	APLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  2  16a. DECEDENT'S USUAL OCCUPA (Give kind of work done during if the Do NOT use retired.)  PROPRIETOR	TION most of working	166. KINO OF BUS	SINESS/INDUSTRY					
ज वित्	1	17. FATHER'S NAME (First, Middle, Leat) MORRIS LOWEN	18. MOTHER'S NAM DEVOR	IE (First, Middle, Maiden : A		NKNOWN				
may be retained or, page 5 should set be notified		196. INFORMANT'S NAME (Type/Print)  MRS . LILYAN LOWEN  206. METHOG OF DISPOSITION  196. MAILING ADDRESS (Street 3041 FALLST 206. METHOG OF DISPOSITION	AFF RD, APT	. 502 BALT	rimore,					
5 6 E		1 X Buriel 2 Cremetion 3 Removel from State 4 Donetton 6 Other (Specify)	427	+1995 BALT		MD				
BALTIN is after death. Pag in by the funeral di removal.	Ц	Day May Louis SOL 6010	LEVINSON  REISTERS	TOWN ROAD	BALTIMO	RE, MD 21215				
ely filled I nation, or		22. PART I Enter the diseases, or complications that caused the death. Do not enter the national shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Finel disease of condition resulting in death)  But TO (OR AS A CONSEQUENCE OF):	node of dylng, such	ss cardisc or respir	ratory arrest,	Approximate interval Between Onset end Death				
th certificate be executed by the certificate be executed by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certificate by the certi	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST  b. OUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  d.								
uires that the signed by the Health and M	5	PART II. Other significant conditions contributing to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting in the underlying to death but not resulting to death but not resulting to death but not resulting to death but not resulting the underlying to death but not resulting to death but not resulting to death but not resulting to death but not resulting the underlying to death but not resulting to death but not resulting to death but not resulting the underlying to death but not resulting to death but not resulting to death but not resulting to death but not resulting to death but not resulting to death but not resulting to death but not resulting to death but not resulting to death but not resulting the death but not resulting to death but not resulting to death but not resulting to death but not resulting to death but not resulting to death but not resulting to death but not resulting to death but not resulting to death but not resulting to death but not resulting to death but not resulting to death but not resulting to death but not resulting to death but not resulting to death but not resulting to death but not resulting to death but not resulting to death but not resulting to death but not result		Pert i. 24s, WAS AN / PERFORI	MED?	b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?  1  YES 2 NO				
	PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  HOSPITAL:  OTHER:		X						
G PHYSICIAN; The this certificate the with the State larked, or Item	PHYS	1 Per 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Ho  27. MANNER OF DEATH 28e. OATE OF INJURY (Month, Day, Year) 1.00 Network 1.00 Nursing Ho	WORK?	Other (Specify) 28d. DESCRIBE HOW IN	JURY OCCUREO					
RATENDING PHYSICIAN: The RECTOR: After the with the State I under death with the State I under the process of them in the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under the state I under th	PO BY	Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be determined   Could not be det	YES 2 NO	281. LOCATION (Street or City or Town, State)	nd Number or Rural	Route Number,				
TAL OB TAN OUR TO UT	OMPL	29e. CERTIFIER (Check only one)  CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, day one)  MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion,				a) and menner as stated.				
TO THE HOSPITAL TO THE FUNERAL De filed within 77 IMPORTANT: I	ro BE CC	296. SIGNATURE AND TITLE OF CERTIFIER  Intern	PSA4023	BER		D (Month, Day, Year)				
6		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)  David Michelsen Singip Hespital Baltim  31. DATE FILED (Month, Day Male)  ANY 0 2 1995	iore							



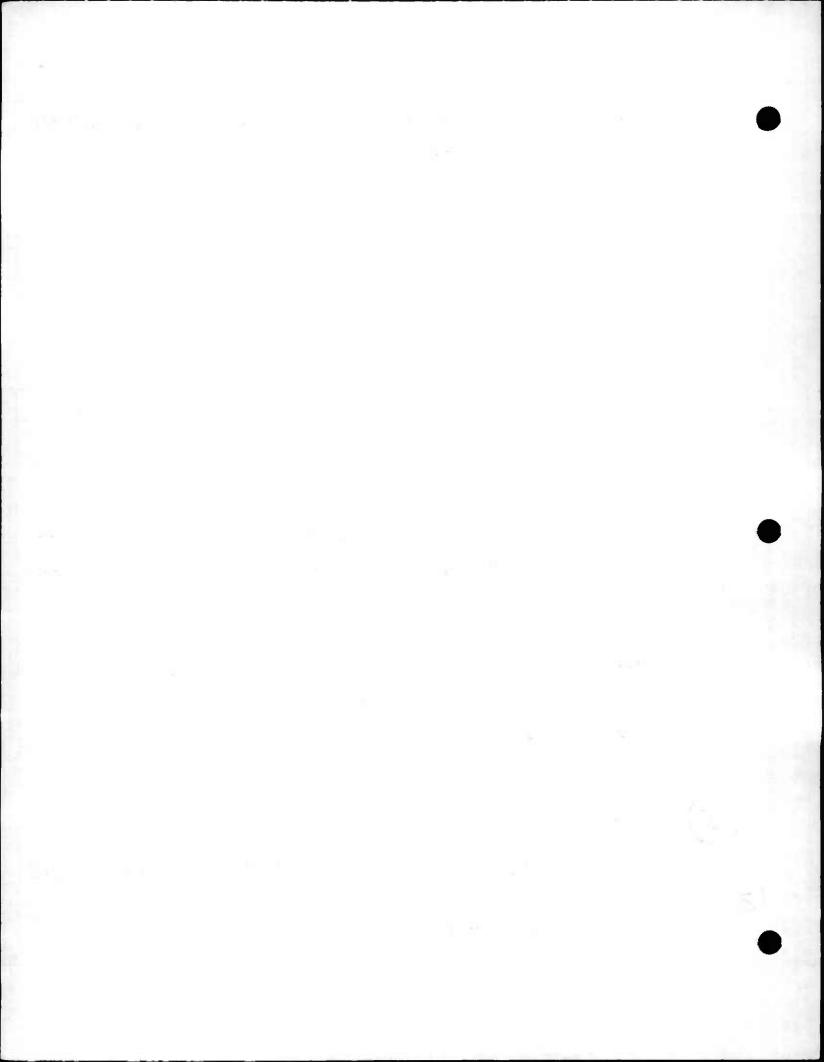
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BALTIMORE, MARYLAND 21215-0020	
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DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO THE HOSPITAL OR ATTENDING PHYSICIAN. The TO THE FINERAL DIRECTOR After this certificate to be filed with 72 feour after death with the State (IMPORTAL). If Amer 24 is marked, or flem

hours after death. Page 6 may be retained by the hospital or attending physician.	3. After this certificate has been signed by the attenting physician and completely filled in by the funeral director, page 5 should be detached for use as the bursa-transf permit. Pages 1, 2, 3 should in death with the State Dept. of Health and Mental Hygiene prior to bursal, cremation, or removal.	medical examiner must be notified at once.
NONG PRYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	9. After this certificate has been signed by the attending physician and completely filled in by the full death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
200		

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last) RUTH	LEVIN			2. DATE OF DEATH DO APRIL D	5 1993	3. TIME OF DEATH  S 2.00P M
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AC 215—18—9942 1 □ M 2 🔀 F	SE (In yrs. lest birthday)  86 YRS.	IF UNDER 1 YE		7. DATE OF BIRTH (Month, Day, Year) SEPT. 10,	8. BI	HTHPLACE (State or Foreign buntry) ARYLAND
	9e. FACILITY NAME (If not institution, give street and number)	00 1115.	9b. CITY, TO	WN OR LOCATION OF DE		9c. COUNTY O	
HOL	SINAI HOSPITAL			BALTIM	ORE	N/	A
DIMECT	10e. STATE 10b. COUNTY	10c. CIT	Y, TOWN OR L			-	10d. INSIDE CITY LIMITS?
AL D	MARYLAND BALTIMORE  100. STREET AND NUMBER		BAI	TIMORE  101. ZIP CODE		10g. CITIZEN C	1 TYES 2 NO
UNER	11 COBBLESTONE CT, APT. T-3			21215		USA	
2	11. MARITAL STATUS  1 Never Married 2 Married  12. WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR OF	ES 2 XNO	If yes	DECENDENT OF HISPAN B, specify Cuben, Mexica YES 2 XNO Specify	n, Puerto Rican, atc.)	8	ACE — American Indian, liack, White, etc.
ED 87	3 X Widowed 4 Divorced						WHITE
	15. DECEOENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5 +)	16a. OECEDENT'S (Give kind of a life. Do NOT us	work done durin	PATION g most of working	16b. KIND OF BUS	INESS/INDUSTR	Y
1	4		AR	TIST		ART	
3	17. FATHER'S NAME (First, Middle, Lust)  JACOB	BROWNSTEIN	1	FANNIE	ME (First, Middle, Malden		ILLING
2	190. INFORMANT'S NAME (Type/Print)  MS. DIANE LEVIN			PONE CT, AP			
Ì	20a. METHOD OF DISPOSITION	20b. PLACE AND DATE	OF DISPOSITION	N (Name of	OATE 20c. LO	CATION - City o	r Town, State
ł	4 Donation 5 Other (Specify)	BALTIMORE	22. NAM	E AND ADDRESS OF FA			, MD
	· Day Way Lewis	),		L LEVINSON LO REISTERS			ORE, MD 21215
	23. PART I. Enter the diseases, or complications that cause or shock, or heart failure. List only one cause or	sed tha daath. Do r	ot antar tha	mode of dying, sucl	as cardiac or respi	ratory arrest,	Approximata Interval Between
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	NARY	EDE	-MA			Onset and Death
	DUE TO (OR A	S A CONSEQUENCE OF	F):	DISEAS			MANY YEARS
2	if any, leading to immediate	S A CONSEQUENCE OF	F):	ソノノレハン			1EAL>
3	CAUSE (Disease or Injury that Initiated events DUE TO (OR A	S A CONSEQUENCE OF	F):				
	resulting in death) LAST					-	
1	PART II. Other aignificant conditions contributing to deat	but not resulting i	in tha under	iying cause given in	Part I. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
Í	RENAL FNSUFFICIENCY				1 [] YES 2	NO NO	COMPLETION OF CAUSE OF DEATH?
1	DID TOBACCO USE CONTRIBUTE TO CAUSE	OF DEATH YE	S Z NO	☐ UNCERTAIN			1 TES 2 NO
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	26. PLACE OF DEAT	OTHER:	one)			
	1 ☐ YES 2 ☑ NO 1 ☐ Input ent 2 ☐ ER/O 27. Manner OF DEATH 28e. DATE OF INJUR	TY 28b, TIM		Home 5 Residence	8 Other (Specify) 28d. DESCRIBE HOW IN	LIURY OCCURED	
	1 Natural 5 Pending (Month, Day, Yea 2 Accident Investigation	r) INJ	M 1	WORK?			
V	3 Suicide 6 Could not be determined 286. PLACE OF INJU building, etc. (S	PRY — At home, farm, a Specify)	streel, factory,	office	281. LOCATION (Street e City or Town, State)	nd Number or Rui	ral Route Number,
1	(Check only one)						
1	MEDICAL EXAMINER: On the basis of exemina  MEDICAL EXAMINER: On the basis of exemina	ition end/or investigatio	n, in my opinic	on, death occured at the			
	Solether M.D.			DEA AS :	5F 9780	AP21	NED (Month, Day, Year) L 25 1995
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF A.S. FLEISHER M.D.			OF BALT			
	MAY 0 2 1995 Julia Musikar Ra						



permit. FUNERAL 5826 Edmondson Avenue this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. 21228 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, OIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 YES 2 ANO Specify: **BALTIMORE, MARYLAND 21215-0020** 1 Never Married 2 Married BY 3 🕅 Widowed 4 🗌 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done life. Do NOT use retired.) stary/Secondary (0-12) College (1-4 or 5+) Owner Grocery notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Pantelis. Katselis Filio Konozis BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 George Lakin 5826 Edmondson Ave Catonsville, Maryland 21228 9 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Greek Orthodox Cemetery 4 Donation 6 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SE 22. NAME AND ADDRESS OF FACILITY Leroy M. & Russell C. Witzke Funeral Homes 1630 Edmondson Avnue, Catonsville, Maryland 21228 medical 23. PART I. Enter the diseases, or complicatione that caused the death. Do not enter the mode of dying, such as cardiec or respiratory street, shock, or heart feiture. List only one ceuse on aech line IMMEDIATE CAUSE (Final event, the Mpo cardial Frefarction disesse or condition resulting in desth) executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760 per fension other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If sny, isading to immediate cause. Enter UNDERLYING OH ATTENDING PHYSICIAN: The law requires that the death certificate be CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 413 heimers shows any DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO MUNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 TES 2 NO 1 ☐ Inpetient 2 CEB/Outpetient 3 ☐ DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 0 27. MANNER OF DEATH 286. TIME OF INJURY 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? marked, there are death v 1 YES 2 NO BY Accident Investigation 3 Suicide 26s. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28 15 28t, LOCATION (Street and Number or Rural Floute Number, City or Town, State) 6 Could not be determined COMPLETED 4 🗌 Homicide 29a, CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CENTURE 29c. LICENSE NUMBER BE 38543 2 CETED CAUSE OF DEATH (ITEM 27) (Type, Print) KEVIN H. SCRUBE

FOR STATE REGISTRAR

214-44-9477

10a. STATE

Maryland

10e. STREET AND NUMBER

31. DATE FILED (Month, Day, Year)

MAY u 2 1995

DIRECTOR

Pages 1, 2, 3

1. DECEDENT'S NAME (First, Middle, Last)

St. Agnes Hospital

RESIDENCE OF DECEDENT

9a. FACILITY NAME (If not institution, give street and number)

10b. COUNTY

Baltimore

EUGENTA LAKTN
4. SOCIAL SECURITY NUMBER

95 13240 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO. 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR 1995 00:12A 7. DATE OF BIRTH B. BIRTHPLACE (State or Foreign September 28,1906 Greece 9c. COUNTY OF DEATH N/A 10d. INSIDE CITY 1 YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 14. RACE — American Indian, Black, White, atc. Specify: White 16b. KIND OF BUSINESS/INDUSTRY 20c. LOCATION - City or Town, Stata May 2, 1995 Woodlawn, Maryland

> **Approximats** interval Between Onset and Death 30 min

CERTIFICATE OF DEATH

IF UNDER 1 YEAR

10c. CITY, TOWN OR LOCATION

Catonsville

IF UNDER 24 HRS.

9b. CITY, TOWN OR LOCATION OF DEATH

10f. ZIP CODE

Baltimore

6. AGE (In yrs. last birthday)

88 YRS.

1 🗌 M 2 📉 F

APRIL

20 yrs

24s. WAS AN AUTOPSY 1 YES 2 NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?

1 TES 2 NO

28d. DESCRIBE HOW INJURY OCCURED

29d. DATE SIGNED (Month, Day, Year)

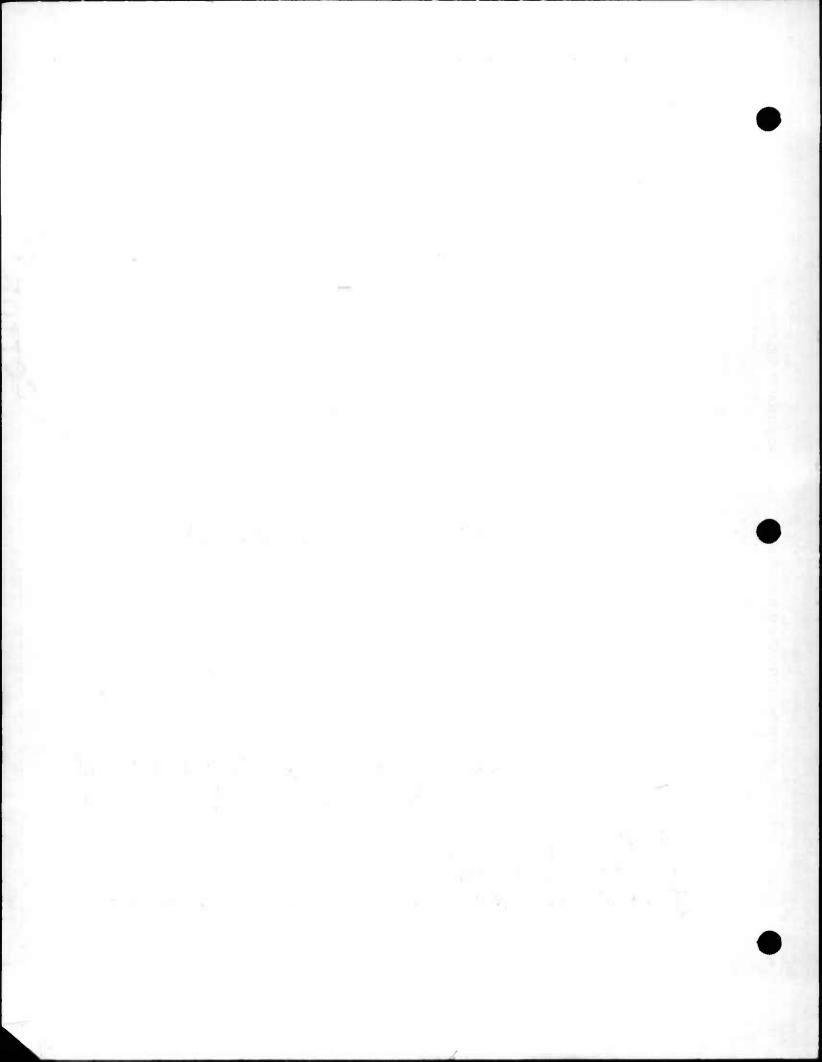
St. Agnes / fospibl GOO CATON AVONUE 32. REGISTRAR'S SIGNATURE

BATIMORE

BKK

ITEMS: 10d,10g,11 ,12,13, & 15, PER MEO FILM G-726 8/23/95 t.t

1 - STATE REGISTRAR CERTIFICATE OF DEATH	REG. NO.										
1. DECEDENT'S NAME (First, Micidio, Last) ALTON MOORE	2. DATE OF DEATH DAY YEAR 3. TIME OF DEATN APRIL 26 1995 10:50P M										
4. SOCIAL SECURITY NUMBER S. SEX 8. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTN 8. BIRTNPLACE (State or Foreign										
175-30-5238 1½ M 2 🗆 F 54 YRS. MONTHS DAYS HOURS MIN.	5-13-40 New York										
LANDS END RD. (WOODED AREA) CENTERVILLE											
10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?										
Delaware  106. STREET AND NUMBER  106. COUNTY  Doc. CITY, TOWN OR LOCATION  Dover	1 ☐ YES X € NO										
½	USA										
15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION	18b. KINO OF BUSINESS/INDUSTRY										
으로 교 12vrs. 2vrs. U.S. Airforce	Federal Government										
4 5 5 0 17. FAITHER'S NAME (FIRST, MICHIEL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STATE ALL STA	AME (First, Middle, Meiden Surneme) Le Prater										
	r, DE 19901										
1   Burlet 2   Cremation 3   Removel from State 4   Donation 5   Other (Specify)   Cremation   State   State   Commeter, crematory or other place)	OATE 20c. LOCATION City or Town, State										
Ronald Wade, Dir. 22. NAME AND ADDRESS OF FA	State Anatomy Board nore St., Balot., MD 21201										
1 PART I Enter the diseases or complications that counsel the death. Do not extend the											
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CAUSE (Disease or Injury that Initiated avents resulting in death) LAST  CAUSE (Disease or Injury that Initiated avents resulting in death) LAST											
, g = 1 = 0	Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS										
PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in	PERFORMED?  AVAILABLE PRIOR TO COMPLETION OF CAUSE										
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAI	OF DEATH?  VES 2 □ NO										
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAL  25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1. V YES 2 NO 1 note that 1 note that 2 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 note that 3 not	N D   /										
25. PLACE OF DEATN (Check only one)  25. PLACE OF DEATN (Check only one)  EXAMINER?  1  YES 2 NO  26. PLACE OF DEATN (Check only one)  HOSPITAL: 1  Inpetient 2 ER/Outpetlant 3 DOA 4 Nursing Home 5 Residence	8 Other (Specify)										
27. MANNER OF OEATN  286. DATE OF INJURY  (Month, Day, Year)  1 Netural 5 Pending  286. DATE OF INJURY  (Month, Day, Year)  1 Netural 5 Pending	28d. DESCRIBE HOW INJURY OCCURED										
28. INJURY AT WORK?  1 Netural 5 Pending Investigation Investigation 2 Accident Investigation 2 Accident Investigation 2 Sec. INJURY At home, farm, street, factory, office	28f. LOCATION (Street and Number or Bural Route Number,										
Nomicide determined building, etc. (Sectiv)	City or flown, State) Wordsend RD										
29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, dats and placs, and dur											
TELLAS ONLY THE AND TITLE OF CERTIFIER	o lime, dats and place, and dus to the cause(s) and manner as stated.										
単	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,										
TABLE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)	timore, Maryland 21201										
MAY 02 1995  32. REGISTRAR'S SIGNATURE											



FOR STATE REGISTRAR

1 -

9c. COUNTY OF DEATH

10g. CITIZEN DF

21:57

10d. INSIDE CITY

E — American Indian, ck, White, etc.

**Approximate** 

Interval Bets

24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 TES 2 ND

Balpmare

Shot

29d. DATE SIGNED (Month, Day, Year)

APRIL 29,1995

restigation, in my opinion, death occured at the time, date and piece, and due to the cause(e) end menner ee stated.

111 Penn Street, Baltimore, Maryland 21201

29c. LICENSE NUMBER

OCME

**Onset and Death** 

WHAT COUNTRY?

YES 2 🗌 NO

P M

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 28, 1995 APRIL ANTHONY R MODICA 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 1 M M 2 | F YRS. 9e. FACILITY NAME (If not inetit. 9b. CITY, TOWN DR LOCATION OF DEATH RECTOR Pages 1, 2, 3 HOCK TRAUMA HOSPITAL BALTIMORE 10c. CITY, TOWN DR LOCATION ō 70P6 een signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit, of Health and Mental Hygiene prior to bunal, cremation, or removal. FUNERAL 10f. ZIP CODE hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECEMDENT OF HISPANIC ORIGIN? (Specify Yes or No. If yes, specify Cuban, Mexican, Puerto Rican, stc.)
 T YES 2 NO Specify: BALTIMORE, MARYLAND 21215-0020 1 🕅 Never Married 2 🔲 Merried BY 3 Widowed 4 Divorced BE COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of work) 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) USTODIAN notified at once. 2 9 Buriet 2 Cremation 3 Donation S Other (Specify) 2064PLACE AND DATE OF DISPOSITION (Name of must 3 - R examiner ERAL SERVICE LICENSEE event, the medical 23. PART / Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line IMMEDIATE CAUSE (Final disease or condition_ chast 10 Gun Shot Wound resulting in death) law requires that the death certificate be executed within OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEDUENCE OF). or other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE DE) If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (DR AS A CONSEDUENCE OF): thet initiated events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? shows any 1 VES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO ightharpoonup Uncertain  $\square$ PHYSICIAN: certificate has b the State Dept. is married, or Item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one SICIAN: The EXAMINER? HOSPITAL: XInpatient 2 ☐ ER/Outpetient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 4-28-TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 13 10 M 95 BY subject 2 Accident 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) PLACE OF INJURY — At home, 3 Suicide farm, street, factory, office COMPLETED 6 Could not be 4 Homicide Roadna 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, TO THE HOSPITAL OF TO THE FUNEHAL DID BE filed within 72 ho

2 X MEDICAL EXAMINER: On the

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Fowler

29b. SIGNATURE AND THEE OF CERTIFIER

Varid

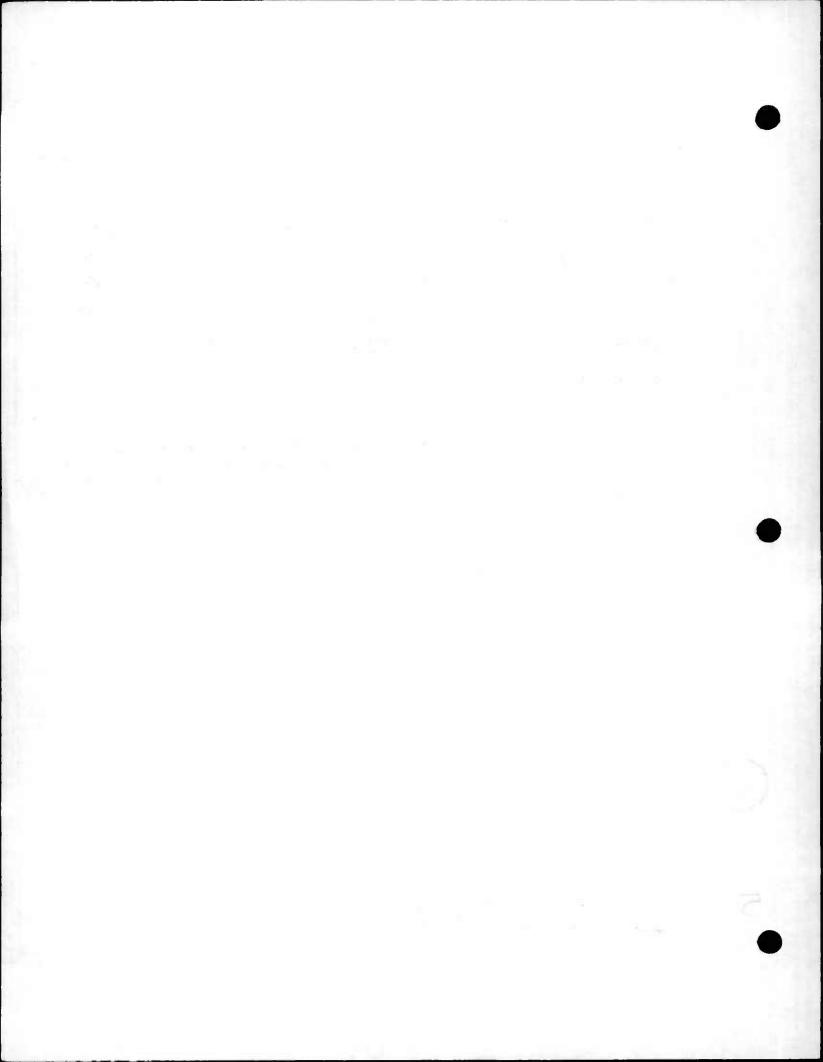
MAY 0 2 1995

BE

5

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

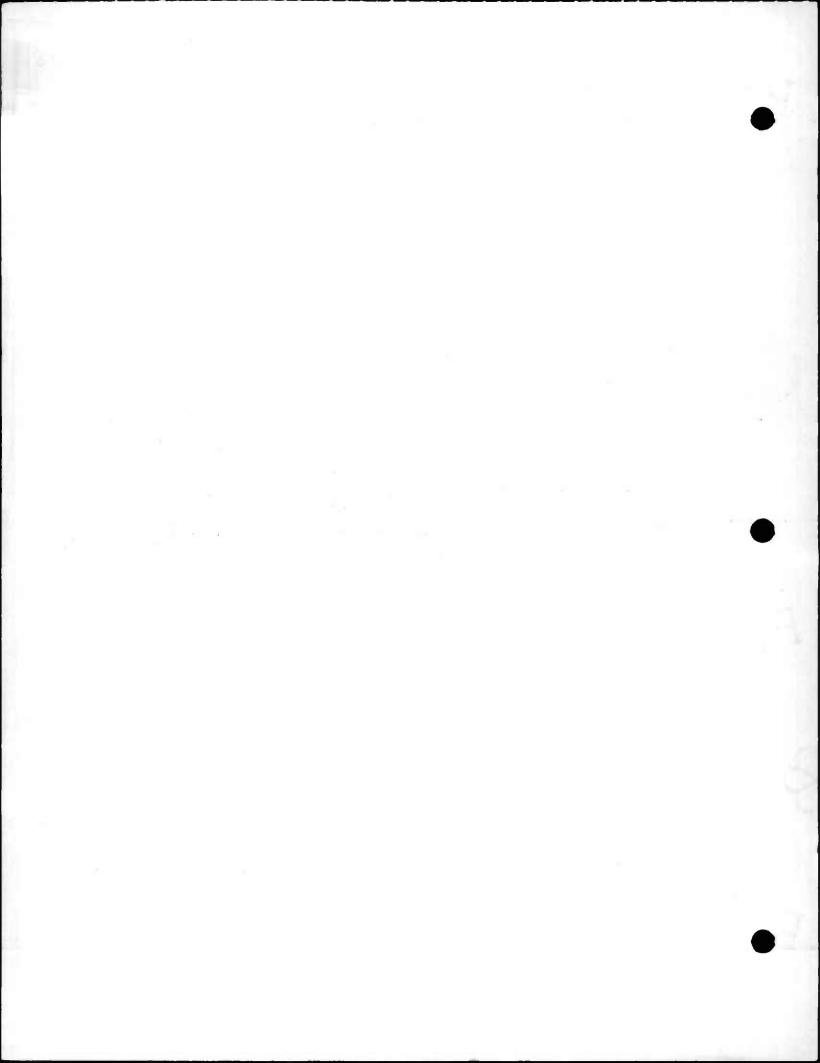
CERTIFICATE OF DEATH



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH EMA 3:00 PM 6. AGE (In yrs. lest birthday IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) MONTHS DAYS HOURS 1X M 2 | F 69 YRS 246-30-2591 APRIL 28 NORTH CAROLINA Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR LIBERTY MEDICAL CENTER BALTIMORE CITY 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND N/Apermit. BALTIMORE CITY TY YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? rours after death. Page 6 may be retained by the hospital or attending physician. If in by the funeral director, page 5 should be detached for use as the burial-transit 3710 CHESHOLM ROAD 21216 USA. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes. specify Cuban, Maxican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, 1 ☐ YES 2 📉 NO 1 Never Married 2 X Married Specify. B 3 Widowed 4 Divorced Specify BLACK ETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify and completely filled in by the funeral director, page 5 should be detached for o burial, cremation, or removal. Elementary/Secondary (0-12) College (1-4 or 5+) COMPL UNKNOWN GROUNDS KEEPER BALTIMORE CITY DIVISION once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) notified at FRANK BE MILLER ANNTE BELL 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MARGARET MILLER 3710 CHESHOLM ROAD, BALTIMORE MARYLAND 21216 must be 20a, METHOD OF DISPOSITION
1 XBurial 2 Cremation 3 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State other place)
LL CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) CEDAR HILL 4-28-95 GLEN BURNIE. the medical examiner 21. SIGNATURE OF AUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE MD 21223 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, **Approximate** shock, or haart feliure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition ±U11 resulting in death) other traumatic event, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within CERTIFICATION Sequentielly list conditions, Hygiene prior to ENCE OF this certificate has been signed by the attending physician with the State Dept, of Health and Mental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese Dr Injury thet initiated events resulting in deeth) LAST 6 Injury, PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 YES 2 NO 1 | YES 2 | NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL item 2 26. PLACE OF DEATH (Check only one **EXAMINER?** OTHER: 1 TES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4 Nursing Home 5 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 28 is marked, 1 Natural 1 YES 2 NO DIRECTOR: After the hours after death visited to the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of th BY Accident Investigation 28a. PLACE OF INJURY - At home, farm, street, factory, office Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If item 2 29a, CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On ale of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated 29b. SIGNATURE AND TITLE OF CERTIFIED BE 29% LICENSE NUMBER 29d. DATE SIGNED, (Month, Day, 1 2 30. NAME AND ANDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ATEM 27) (Type, Print) 600 31. DATE FILED (Month 1995 2 0

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



		1 - STATE REGISTRAR	STATE OF MARYLAND / DEPA CERTII	RTMENT OF HEALTH AND FICATE OF DEATH	MENTAL HYGIEN		
		1. DECEDENT'S NAME (First, Middle, Last) MARROW.	Amy		2. DATE OF DEATH	-8,199	3. TIME OF DEATH
_		4. SOCIAL SECURITY NUMBER	5. SEX AGE (In yrs. last birthday) 1  M 2 WF YRS.	(f) IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH OMONTH, Day, Wash	8. Bil	RTHPLACE (State or Foreign   Unitry)
2, 3 should	В	Sa. EACILITY NAME (Minot institution, give str	me Hospital	96. CITY, TOWN OR LOCATION OF D Baltimor	DEATH	9c. COUNTY O	FOEATH
Pages 1, 2	DIRECTOR	RESIDENCE OF DECEDENT  100. STATE  100. COUNTY	100. 9	TOWN DR LOCATION		1.1	104. HENDE CITY
permit. Pa		Maryland 100. Street and Number	N/A I	Baltimore 101, ZIP CODE		T too CITIZEN O	1 (12 YES 2   NO
rian. -transit	FUNERAL	3827 Bowe	12. WAS DECEDENT EVER IN U.S. ABMED	2120	7	l u	SA
21215-0020 al or attending physician for use as the burial-tra	BY	1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ABMED FORCES? 1 [ YES 2 [ V NO IF YES, GIVE WAR DR DATES	13. WAS DECENDENT OF HISPA If yes, specify Cuban, Mexic 1 ☐ YES 2 ☑ NO Speci	en, Puerto Rican, atc.)	or No-	ACE American Indian, lack, White, etc.
2121; al or atten for use a	ETED.	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	100100000111	'S USUAL OCCUPATION If work done during most of working use retired.)	16b. KIND OF BUS	SINESS/INDUSTR	1
	COMPL	17, FATHER'S NAME (First, Middle, Last)	Compe	ensation Adju	Stor U		vernment
1 8 8 A	BE C	Leslie We	- 0	anklin Min	AME (First, Middle, Majden	are	
	10	Lesie Wes	5+ 382	AG ADDRESS (Street and Number or Rurel)	Ave. Ba	TO, M	1.21207
MORE, le 6 may be rector, page		20e. METHOD OF DISPOSITION 1 V Buriel 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	ovel from State	other blace)	5/3/95 / C	CATION - CITY OF	Town, State
BALTIMORE, er death. Page 6 may b the funeral director, page val.		21. SIGNATURE OF FUNERAL SERVICE LICE		22. NAME AND ADDRESS OF A	uss Fun	eral	Hame 1216
in by remo		23. PART   Enter the dispesses, Dr cr shock, or heart feiture. I	emplications that caused tha death, Do List only one cause on each line.	not antar tha mode of dying, suc	ch aa cardiac Dr respi	iretory srrest,	Approximats interval Batween
hin 24 I tely fille mation, it, the		iMMEDIATE CAUSE (Final disease or condition resulting in death)	B. METASTATIC  DUE TO (DR AS A CONSEDUENCE O	c CANCER	OF COL	10N	Onset and Death
687 executed and com burial,	NO	Sequentially list conditions,	b,				
00 4 5 7	RTIFICATION	If sny, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR AS A CONSEDUENCE C				
P.O.	CERTIF	thet initiated eventa resulting in death) LAST	DUE TO (DR AS A CONSEDUENCE D	ΣF):			
ADS the of the br>the of the br>the of the of the of the of the of the of the of the the of the of the br>the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of the of	CAL C	PART II. Other aignificant conditions	s contributing to death but not resulting	in the underlying cause given in	Part I. 24a, WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
w requires that seen signed by pt. of Health and 3 shows any	MEDIC				1 _ YES 2	COLUMN TO SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERVICE SERV	COMPLETION OF CAUSE OF DEATH?
- 2 8 2 C		DID TOBACCO USE CONTR	RIBUTE TO CAUSE OF DEATH Y	TES NO UNCERTAI	ND		1 1 129 2 1 110
PHYSICIAN: The this certificate h, with the State C	PHYSICIAN:	EXAMINER?	HOSPITAL: 1   Inpatient 2   ER/Outpatient 3   DOA	OTHER: 4 % Nursing Home 5 - Residence	8 Other (Specify)		
- a a > E	ву Рн	27. MANNER OF DEATH  1  Netural 5 Pending 2  Accident Investigation	28e. DATE OF INJURY (Month, Day, Year) 28b. TIN	ME DF UNITY  M 1 YES 2 ND	28d. DESCRIBE HOW IN	NJURY OCCURED	
ISIC TTENDI TTENDI TOR: A after da	ΕĒ	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At home, ferm, building, etc. (Specify)	atreet, fectory, office	281. LOCATION (Street et City or Town, Stete)	ind Number or Run	si Route Number,
7 - 2 -	COMPLE		CIAN: To the best of my knowledge, death occurs.  3: On the basic of examination end/or investigation.				e(e) end manner ee stated.
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: If	BE	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUI			ED (Month, Day, Year)
5 6 8 ₹	٩	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH (ITEM 27) (Type)  NAZEM! M	e, Print)	322	APIL	12811995
40		or. Drite I leed (Moralli, Day, 1661)	- NAZEMI M	-D. CHURCH	HOSP- 6	BALT.	21231
		MAY 02 1995	yala Dudwarkarlar				

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Nem 28 is marked, or Nem 23 shows any Injury, or other traumatic event, the medical examiner must be notitied at once.

								D	J	1954	J
	1 - STATE REGISTRAR	STATE OF MARYLAND	/ DEPAR	RTMENT OF	HEALTH AND	MENTAL	HYGIEN REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE O	F DEATH	AY	YEAR	3. TIME OF DEAT	
	CAROL	MEEKINS				APRI		2	1995	9.30	P.M
	4. SOCIAL SECURITY NUMBER 214-44-9577		49 yrs.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.		PERTN Day, Year)		a. BIRTH Countr	IPLACE (State or Fo	reign
OR O	90. FACILITY NAME (If not institution, give to Good Samaritan, 5		Blvd.	96. CITY, TOWN Balt:	more	DEATN		9c. CO	UNTY OF D	EATH	
5	RESIDENCE OF DECEDENT  10a, STATE  10b, COUNT										
DIRECTOR	Maryland	Υ		altimore						10d. INSIDE CITY LIMITS? 1 YES 2	
FUNERAL	700 N. Kenwood Av	re.		10	21205			10g. CI	TIZEN OF V	VHAT COUNTRY?	
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES		It yes, s	CENDENT OF NISP ecity Cuben, Mexi 2 NO Spec	cen, Puerto Ri	(Specify Year cen, atc.)	o or No—	Black	American India c, White, etc.	en,
	15. DECEDENT'S EDU	CATION	SECTION 1	USUAL OCCUPATI		-				wnite	
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	completed)	Give kind of the Do NOT us	work done during m	ost of working	166. (	KIND OF BU	SINESS/IN	IDUSTRY		
	17. FATNER'S NAME (First, Middle, Lest)				18. MOTNER'S N	AME (First, Mi	ddle, Melden	Surname)			
TO BE	19e. INFORMANT'S NAME (Type/Print)	1	19b. MAILING	ADDRESS (Street	and Number or Run	Il Route Numbe	r, City or Tow	n, State, Z	(ip Code)		
	20e. METNOD OF DISPOSITION 1 Burlel 2 Cremation 3 Rem	oval from State cometery, c	E AND DATE or or or or or or or or or or or or or	OF DISPOSITION (Nather place)	ame of	DATE	20c, LO	CATION -	- City or To	wn, State	
. 0	4 Donation 5 Other (Specify) 1		Difa	22 NAME A	ND ADDRESS OF I		1	A == = 4		Description	
	mull 1	Il level	DII.		7. Balti						
-	23. PART I. Enter the diseases, or shock, or heart fallure.	complications that caused the c List only one cause on each lin	leath. Do r	not sater the mo	de of dying, su	ch se cerdi	sc or reap	Iratory a	rrest,	Approxima	
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	ANOXIO		ENC	EPHA L	OPAT	HV			Onset and	
	resulting in destri)	DUE TO (OR AS A CONS			Ca 717-( -	- / / /	/ / /			TOR	icur
z	was source and	b								appn	DX
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONS	EOUENCE OF	F):						111	
2	CAUSE (Disease or Injury	c									
Ë	thet initiated avents resulting in death) LAST	DUE TO (OR AS A CONSI	EQUENCE OF	F):							
Ë		d									
. 1	PART II. Other significant condition	a contributing to death but not	resulting	In the underlyin	g cause given i	n Part I.	4a. WAS AN		24b.	WERE AUTOPSY FIR	
MEDICAL	MULTIPL	E OVA'S					PERFOR	-		AVAILABLE PRIOR 1	
ME	SEPSIS							ag no		DF DEATH?	r6
ż	DID TOBACCO USE CONT	RIBUTE TO CAUSE OF DEA	ATH YE	S   NO	UNCERTA	IN 🗆				1 1 100 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
ĕ.	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		CE OF DEAT	TH (Check only one)							
Š	1 TYES 2 PNO	HOSPITAL: 1 Propettent 2 ER/Outpettent	3 🗆 DOA	OTHER: 4 Nursing Horr	e 5 🗆 Residence	8 Other (	Specify)				
BY PHYSICIAN:	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM	URY WO	URY AT RK?	28d. DESC	RIBE NOW II	NJURY OC	CURED		
	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — At h building, etc. (Specify)	ome, ferm, a	street, factory, offic		28t. LOCAT City or	ION (Street a Town, State)	and Numbe	or Rural R	oute Number,	
COMPLETED	29e. CERTIFIER (Check only one)	CIAN: To the best of my knowledge, d	leath occurre	ed at the time, date	and place, and du	e to the cause	e(e) end man	ner ee ats	ited.		
00	2 MEDICAL EXAMINE	R: On the basis of examination end/or	Investigatio	n, in my opinion, d	eath occured at th	e time, date a	nd place, en	d due to t	ha cause(e)	and manner ea st	ated.
BE (	296. SIGNATURE AND TITLE OF CERTIFIER		1 1		29c. LICENSE NU			29d, DA1	TE SIGNED	(Month, Day, Year)	
2	Mayal		1.1		PO 8	236			04 2	2/95	
-	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DEATH (IT	EM 27) (Type,	Print)					-	1	

GOOD

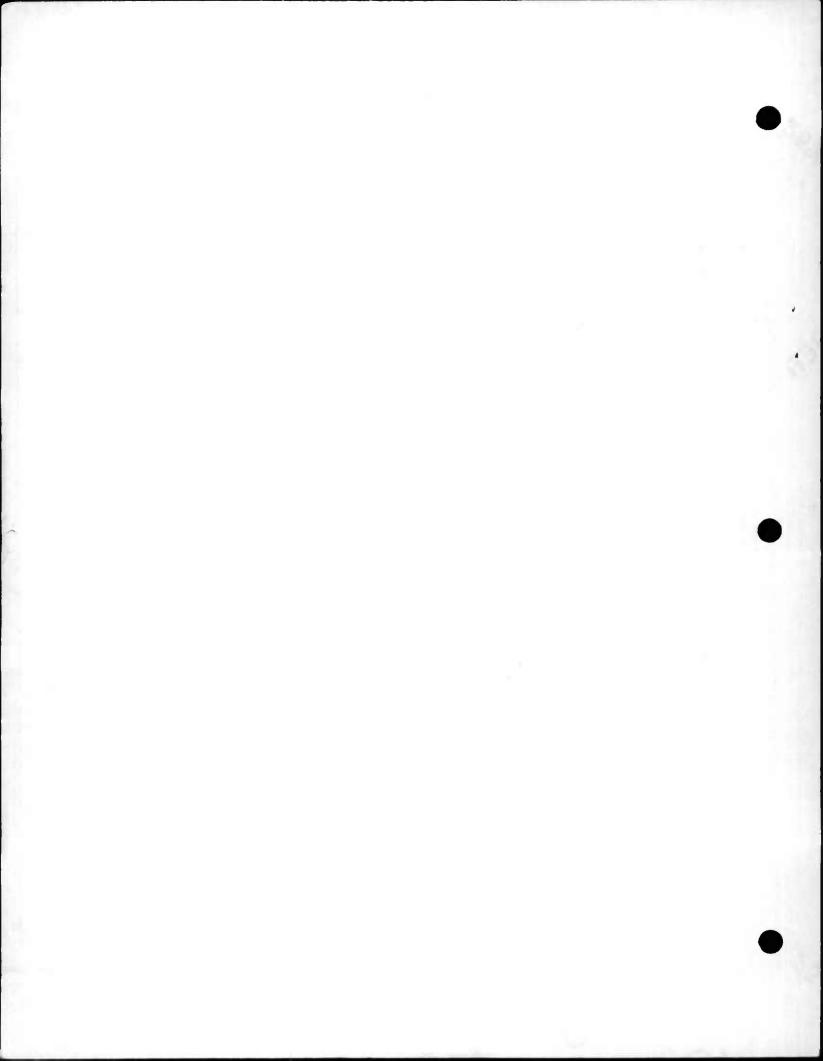
SIGNATURE CONTROLL

32. REGISTRAR'S SIGNATURE

MAY 02 1995

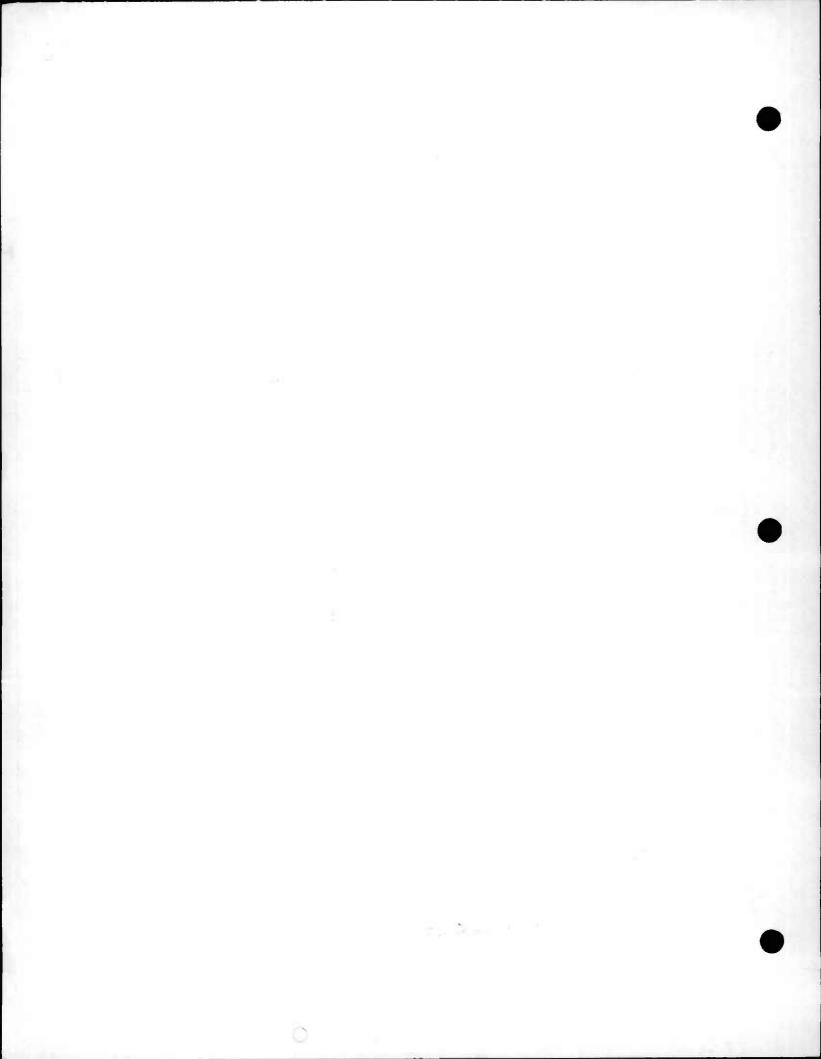
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HOSPITAL



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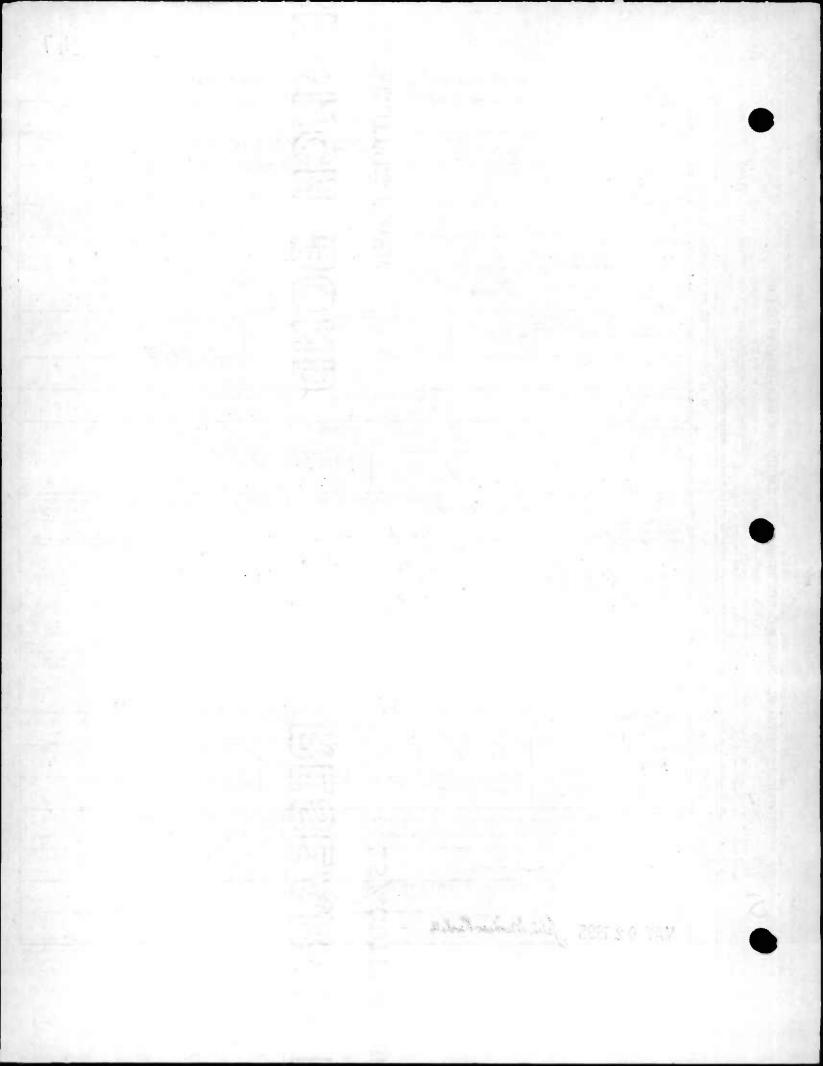
		1 - FOR STATE OF MARYLAND / CE	DEPARTMENT OF H		TAL HYGIENE REG. NO.	70 101.40				
		1. DECEDENT'S NAME (First, Middle, Last)	MORRISS	E 4,5R A	ATE OF BERTH	19 SEAR 3. TIME OF OEATH M				
pinous		167-14-4722 1 💢 M 2 🗆 F 87  9a. FACILITY NAME (if not institution, give street and number)	YRS. MONTHS DAYS	HOURS MIN. (A	rch 15, 1908	Country)				
1, 2, 3	ECTOR	ac doubt of be								
nit. Pages	DIR	Pennsylvania Lebanon County	10c. CITY, TOWN OR LOCAT	TON		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO				
in. ansit permit.	VERAL	Route 4 Box 1360	101.	. ZIP CODE 17042	10g.	CITIZEN OF WHAT COUNTRY? U.S.A.				
5-0020 Inding physician. as the burial-transit	BY FUN	11. MARITAL STATUS  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was DECEOENT EVER IN U.S. ARM FORCES? 1 VES 2 No. IF YES, GIVE WAR OR OATES	O If yes, spe	ENOENT OF HISPANIC OR polity Cuben, Mexican, Pua 2 X NO Specity:	IGIN? (Specify Yea or No rto Rican, atc.)	14. RACE — American Indian, Black, White, alc. Specity: White				
or atte	LETED	(Specify only highest grade completed) (Giv	CEDENT'S USUAL OCCUPATION kind of work done during most Do NOT use retired.)	ON st of working	18b. KIND OF BUSINESS	S/INDUSTRY				
the hospital detached for	COMPL	17. FATHER'S NAME (First, Middle, Last)	Steel Worker		Steel 1					
\$ 2 E		Michael Morrissey		16. MOTHER'S NAME (File	st, Middle, Maiden Suman elev	ne)				
retained 5 should notified	TO BE		. MAILING ADDRESS (Street a	nd Number or Rural Route N	lumber, City or Town, State	s, Zíp Code)				
y be	-		3652 Sykesvi							
		1 A Burtai 2 Cremation 3 Removal from State cemetery, crem	ND DATE OF DISPOSITION (National or other place)	1.100		N - City or Town, Stata all, Pennsylvania				
leath. Page funeral direct		21. SIGNATURE OF FUNERAL SERVICE LICENSEE		D ADDRESS OF FACILITY						
		► Brian A. Akuight HAIGHT FUNERAL HOME (P.O. Box 195) Sykesville, MD 21784 (410)-795-1400)								
£4 hou filled in ion, or he m		23. PART I. Enter the diseases, or complications that caused the das abook, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)				Approximata interval Batween Onset and Dasth				
a co ed	z	DUE TO (OR AS A CONSECULATION OF AN CY TO)	UENCE OF):			/weec				
. 8 0 6	CATION	Sequentially list conditions,  If any, leading to immediate	UENCE OF):	17 0.60	0	(yeur c				
th certificat ending phy il Hygiene p	ERTIFIC	CAUSE (Disease or Injury that Initiated events resulting in death) LAST	LOPL 184A  UENCE OF:  Carcinoni		as c	lyear				
E 48 6	L C	PART II. Other algnificant conditions contributing to death but not re	aulting in the undarlying	cause given in Part I	24a. WAS AN AUTOP	PSY 24b. WERE AUTOPSY FINDINGS				
law requires that the las been signed by the last. 23 shows any In	MEDICA	Hypertension Browcle	4775	ersis	PERFORMED?	AVAILABLE PRIOR TO				
Seas 2	AN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEAT 25. WAS CASE REFERRED TO MEDICAL 26. PLACE	H YES NO	UNCERTAIN						
E 88 E	SICI	EXAMINER?  t  YES 2 NO	OTHER:	5 🗆 Realdence 8 🗆 0	Wher (Specify)					
NG PHYSICIAN: The state this certificate that with the State marked, or item	ву рну	27. MANNER OF DEATH  1 Netural 5 Pending (Month, Dey, Year)  2 Accident Investigation	28b. TIME OF 28c. INJURY WOI	JRY AT 28d.	DESCRIBE HOW INJURY	OCCURED				
TTENDII A after de 28 18	<u>a</u>	3 Suicide 8 Could not be detarmined 28a. PLACE OF INJURY — All home building, alc. (Specify)	ie, farm, streel, factory, office		OCATION (Street and Num lity or Town, Stete)	mber or Rural Route Number,				
돌팔었는	COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, destrone) 2 MEDICAL EXAMINER: On the basis of examination and/or in								
TO THE HOSPI TO THE FUNEF DE filed within	O BE	206. Signature and title of certifier Cay (1. Smellede M)		20c. LICENSE NUMBER		DATE SIGNED (Month, Day, Year)  Will 76/1995				
5		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM  SCHALL (SPENIA M)	27) (Type, Print) 200 MEMUN	ene ste,	we soun	sex usiyes				
		MAY 0 2 1995				21157				



BALTIMORE, MARYLAND 21215-0020	tours after death. Page 6 may be retained by the hospital or attending physician.	7 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should if fled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with cours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, i	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at ence.

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.

REGISTRAR											
1. DECEDENT'S NAME (First, Middle, Lest)  Josephine	т.		Neul	naus			2. DATE OF MONTH	DEATH DA	ŏ, 1	YEAR 995	3:00 A
4. SOCIAL SECURITY NUMBER 071-18-5886		AGE (In yrs. last birthday) IF UNDER 1 Y 78 YRS. MONTHS D			(Month Day Year		BIRTH lev Mari		Countr		
	1 M 2 F	/0	THO.					12,1	1917	New	York
9a. FACILITY NAME (If not institution, give a Anne Arundel	Medical	Cente	er			OR LOCATION OF D	EATH		9c. COUNTY OF DEATH Anne Arundel		
RESIDENCE OF DECEDENT			_								
Marky land Anna			TY, TOWN		TION					10d. INSIDE CITY LIMITS?	
	Maryland Anne Arundel				is						1 - YES 2 NO
1310 Cape St. Cl	aire Rd.				10	21401					States
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2 X			If yes, sp	CENDENT OF HISPA Decity Cuben, Mexic S 2 NO Speci	en, Puerto Rici	Specify Yea an, etc.)	or No—	14. RACE Black Speci	— American Indian, k, Whita, atc.
15. OECEDENT'S EDU		16a, D	ECEDENT'S	S USUAL O	CCUPATI	ON	16b. K	ND OF BUS	SINESS/INI	DUSTRY	***************************************
(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+		Give kind of e. Do NOT u	work done use retired.)	during me	ost of working					
12	Conege (1-4 b) 5 4		autic	rian			CO	smeto	logy		
17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NA					
Vita Teti											
		-				1	la Pro				
19a. INFORMANT'S NAME (Type/Print)						and Number or Rural					
Vito DeLorenzo						ay, Annaj					
20a. METHOD OF DISPOSITION  1 Burlal 2 Termation 3 Ram  4 Donation 5 Other (Specify)	oval from State	20b. PLACE	AND DATE	OF DISPOS	ry,	Inc.					wn, State , Maryland
21. SIGNATURE OF FUNERAL BERVICE LA	CENSEE					ND ADDRESS OF FA					, mary rain
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23. PART I. Enter the diseases, or shock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cau	sé on each lin	0 0	4 npt enter	21 (	Crain Hwy	th an cardis		len	Burn	Approximata Interval Between Onset and De
IMMEDIATE CAUSE (Final disease or condition	a. DUE TO	I de on each lin	EOUENCE C	DF):	21 (	Crain Hwy	th an cardis		len	Burn	Approximata Interval Between Onset and De
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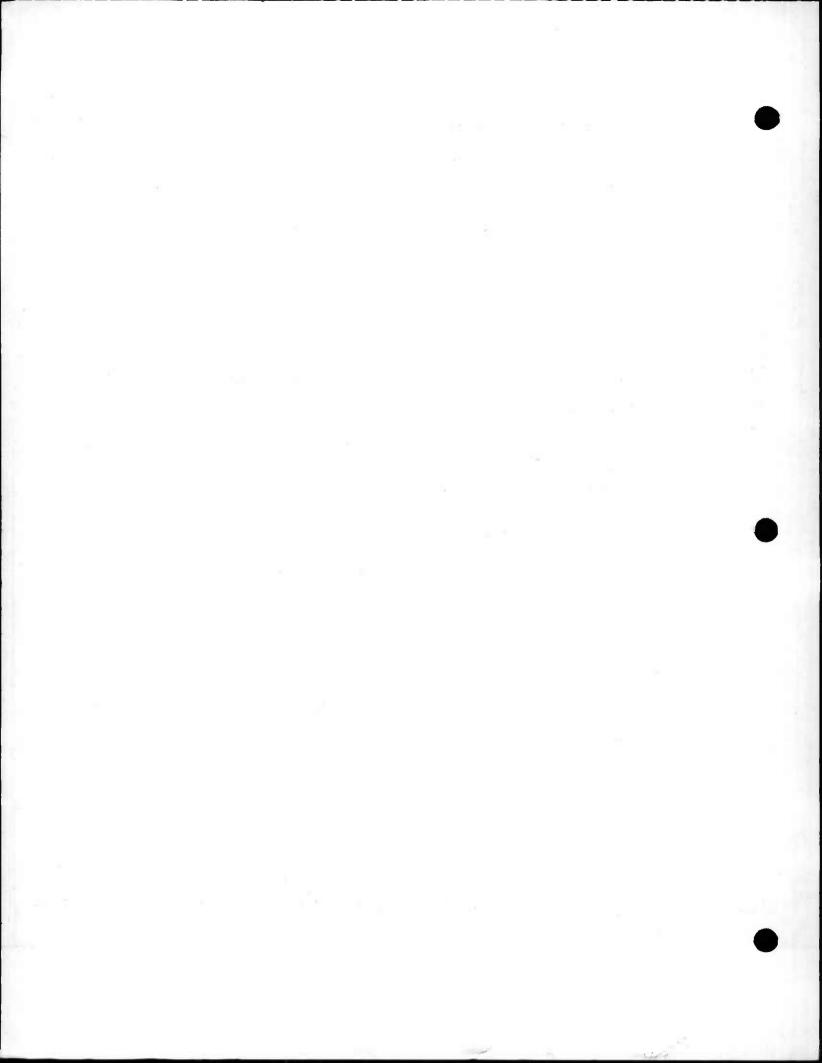
DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

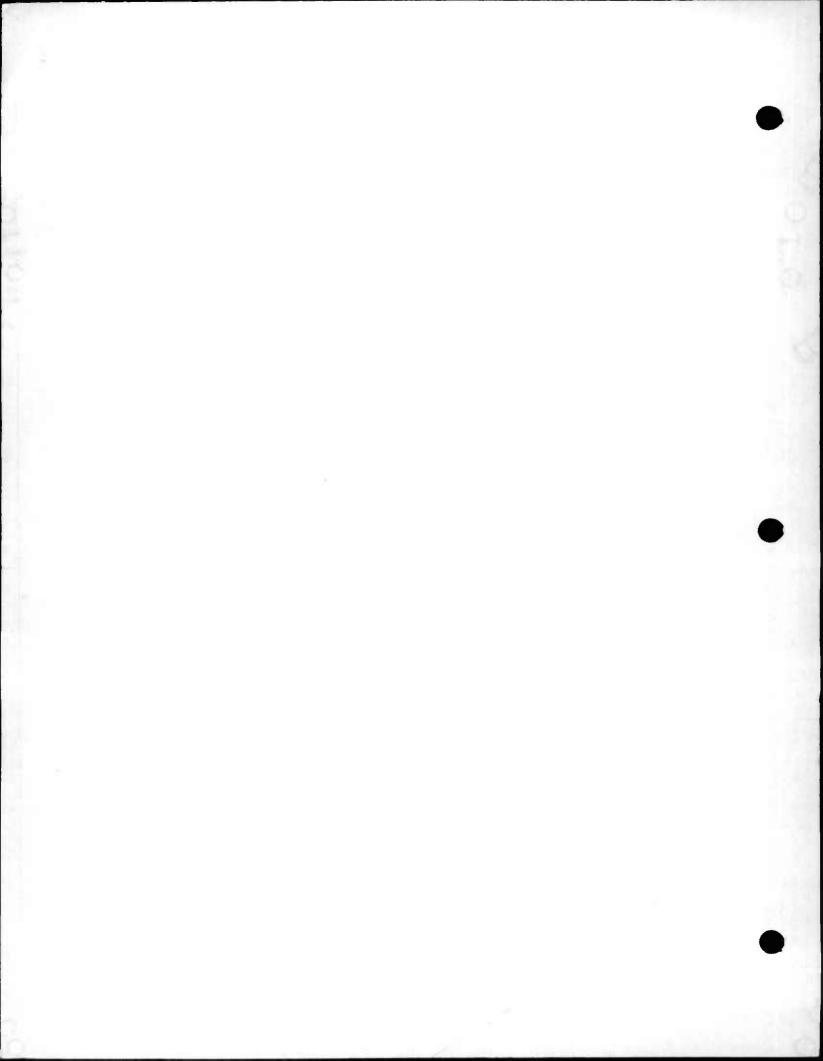
STATE OF	MARYLAND /	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIENE	
	C	ERTIFICATE	O	F DEAT	ГН		BEG NO	

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
- 1	1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH 3. TIME OF DEATH								
- 5	CARROLL NELSO	<u> </u>		MONTH 4	27 YEAR	1:10 PM				
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE	THE DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)						
	579-30-2162 1XX M 2 □ F 6		July 4, 1928	B Mary	land					
œ	9a. FACILITY NAME (If not institution, give street and number)	CITY, TOWN OR LOCATION OF D	EATH	9c. COUNTY OF DEATH						
5	Laurel Regional Hospital		Laurel		Prince George					
REC	10a. STATE 10b. COUNTY	10c. CITY, TO	WN OR LOCATION		10d. INSIDE CITY LIMITS?					
ā	Maryland Prince George		Laurel			XX YES 2 □ NO				
RAL	10e. STREET AND NUMBER	10t. ZIP CODE		10g. CITIZEN OF V	VHAT COUNTRY?					
FUNERAL DIRECTOR	14938 Belle Ami Drive 11. MARITAL STATUS 12. WAS DECEDENT EVER 0	VIII O ADVISO	20707		USA					
BY FU	1 Never Married 2XXX Married FORCES? 1 YES IF YES, GIVE WAR OR D	2 X XNO	13. WAS DECENDENT OF HISPAI If yes, specify Cuban, Maxico 1 YES 2 NO Specifi	an, Puarto Rican, etc.)	Yea or No— 14. RACE — American Indian, Black, Whita, atc.  Specify: White					
	15. DECEDENT'S EDUCATION	16a. DECEDENT'S USUA	AL OCCUPATION	16b. KIND OF BUS	SINESS/INDUSTRY					
COMPLETED	(Specify only highest grade completed)  Elamentary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT use reti	done during most of working red.)							
MP	10 Ø	Senior Lock	Maker	U S Post	al Service					
8	17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NA	AME (First, Middle, Maiden	Surname)					
BE	Paul Nelson  19a. INFORMANT'S NAME (Type/Print)		Daisy Ma							
2	Marianna R. Nelson		RESS (Street and Number or Rural lle Ami Drive, L							
	20a. METHOD OF DISPOSITION 201	. PLACE AND DATE OF DIS			CATION — City or To	nern. State				
	1 A Burial 2 ☐ Cremation 3 ☐ Ramoval from State   Cer	netary, crematory or other p dar Hill Ceme	lace)	1	Committee Committee					
-	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY Fleck Funeral Home, Inc.									
	· Kalada leako		7601 Sandy Sprin	ng Ŕoad, Laur		)7				
	23. PART / Enter the diseases, or complications that cause shock, or heart fellure. List only one cause on	The death. Do not e	ntar tha mode of dying, suc	th as cardiac or respi	ratory arrest,	Approximata Interval Between				
	IMMEDIATE CAUSE (Finel									
	resulting in death)  PROSTATE C THOUSENESS OF ETASTATIC									
_	disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions,  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):									
5	If any, leading to immediate									
S	CAUSE (Disease of Injury									
	thet initiated events resulting in death) LAST	CONSEQUENCE OF):								
CERTIFICATION	d									
CAL	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED?  AMALABLE PRIOR									
	PERFORMED?   AM   1									
MEDI										
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE C			N 🗆						
i Ci	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   YES 2   NO		HER:							
HYS	1 VES 2 NO 1 Inpetiem 2 ER/Out	28b. TIME OF	Nursing Home 5 Realdence							
	1 Natural 5 Pending (Month, Day, Year)	INJURY	WORK?  M 1 YES 2 NO	28d. DEŞCRIBE HOW INJURY OCCURED						
Э ВУ	2 Accident Investigation 3 Suicida 8 Could not be building at / Soe	- At home, farm, street	factory, office	28f. LOCATION (Street and Number or Rural Route Number,						
	4 Homicide datarmined building, atc. (Specify)  City or Town, State)									
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best ot my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as attend.									
O.	one)  2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.									
BE 0	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUI	MBER	29d. DATE SIGNED	29d. DATE SIGNED (Month, Day, Year)				
면 인	Betelle 1/11	~	0450	14	1 4/27/95					
-		ATH (ITEM 27) (Type, Print)	D 7350	VAN DU	My Val	1 1-00				
	31. DATE FILED (Month, Day Seat) 122 EGISTBAR'S MON		(0 .345	171.4 1303		LAURCE				
	31. DATE FILED (Month, Day Sept. 32 EGIS PARS)	K64								



31. DATE FILED (Morith, Day, Year)
MAY 0 2 1995

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR  CERTIFICATE OF DEATH  1. DECEDENT'S NAME (First, Middle, Last)												
	John	1							YEAR	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER	Neil 5. SEX	6. AGE (In yrs. la	me bloth day	or inspec	R 1 YEAR		R 24 HRS.	4		_	5	7:47 p
	400 22 4952	1 ☑ M 2 ☐ F	71	AN	MONTHS	DAYS	HOURS	MIN.	(Mont	OF BIRTH		Counti	
DIRECTOR	9e. FACILITY NAME (If not institution, give				ob CITY	V TOWAL C	TOWN OR LOCATION OF D		9-7-23		-	Kentucky COUNTY OF DEATH	
	Washington County Hospital Hagerstown										PEATH		
	10a. STATE 10b. COUN	ITY		16c, CITY, TOWN OR LOCATION								10d. INSIDE CITY	
	Maryland Was	shington		Williamsport									LIMITS? 1 YES 2 NO
FUNERAL	10706 Honeyfield	d Road				101	. ZIP COD	€ 1795				S.	WHAT COUNTRY?
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 $\times$ YES 2 $\setminus$ NO If YES, GIVE WAR OR DATES 1 $\times$ 42 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ 1 $\times$ YES 2 $\times$ YES 2 $\times$ YES 2 $\times$ YES 2 $\times$ YES 2 $\times$ YES 2 $\times$ YES 2 $\times$ YES 2 $\times$ YES 2 $\times$ YES 2			pecify Cuban, Mexican, Puerlo Ricen, etc.)						E — American Indian, k, White, etc.		
8	15. DECEDENT'S ED (Specify only highest gra-	UCATION	16a. Di	ECEDENT'S	USUAL O	CCUPATIO	N N		168	. KIND OF BUS	SINESS/INDU	STRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 +	1/6	Give kind of v a. Do NOT us Phy:	work done se retired.) SiCi		st of worki	ng		Medi	ćine		
NO.	17. FATHER'S NAME (First, Middle, Lest)						18. MOT	NER'S NA	ME (First,	Middle, Meiden	Surname)	-	
LLI I	William Randal	l Neill					D	orot	hy D	ent Mo	remen	" WE'ST	
5	John Neill		19	b. MAILING	ADDRES:	S (Street e	nd Numbe	r or Rural	Route Num	ber, City or Tow	n, State, Zip (	Code)	
	20e. METHOD OF DISPOSITION  1 Deniel 2 Commettion 3 Removal from State  20b. PLACE AND DATE OF DISPOSITION (Name of cometery, cremetory or other piece)  20c. LOCATION — City or Town, State									own, State			
	21. POPATURE OF FUNERAL SERVICE	ICENSEE Ronal	d Wade,	Dir		NAME AN				State t., Ba			
CERTIFICATION	23. F/RT I. Enter the diseases, or ahock, or heart failure immediate CAUSE (Finel disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	e. DUE TO	of as a conse	OUENCE OF	SSIR Teur	ll ese					retory arre	st,	Approximate Interval Between Onset end Death
	PART II. Other algorificent condition	d	death but not	reculting I	n the un				D. a. 1			T.	
: MEDICAL CE								/	_	24a. WAS AN PERFOR 1 TYES 2	MED?	246.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
AN	DID TOBACCO USE CON  25. WAS CASE REFERRED TO MEDICAL	IKIBUTE TO CA		TH YE			UNC	ERTAI	4 🗆				
PHYSICIAN:	EXAMINER?	HOSPITAL:			OTHER		5 🗆 Re	esidence	6 🗆 Othe	er (Specify)			
ВУ РН	27. MANNER OF DEATH  1 Description 5 Pending Investigation	(Month, Da	28e. DATE OF INJURY (Month, Day, Year)  28b. TIME OF 1NJURY AT WORK?  M 1 YES 2 NO				28d. DEŞCRIBE HOW INJURY OCCURED NO						
8	3 Suicide 6 Could not be determined	28e. PLACE Of building,	FINJURY — At ho letc. (Specify)	ome, farm, a	treet, fect	tory, office				ATION (Street e or Town, Stete)	nd Number o	r Rurel F	loute Number,
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHY 2 MEDICAL EXAMIN	SICIAN: To the best of IER: On the basis of ex											) end manner ee stated.
TO BE COM	296. SIGNATURE AND TITLE OF CENTER		- An	Was	W.E		29 LICE	ENSE HUN	IBED -				16 T
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF BEATH HITTONIA Print AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODELLA PRINT AUD MODEL												

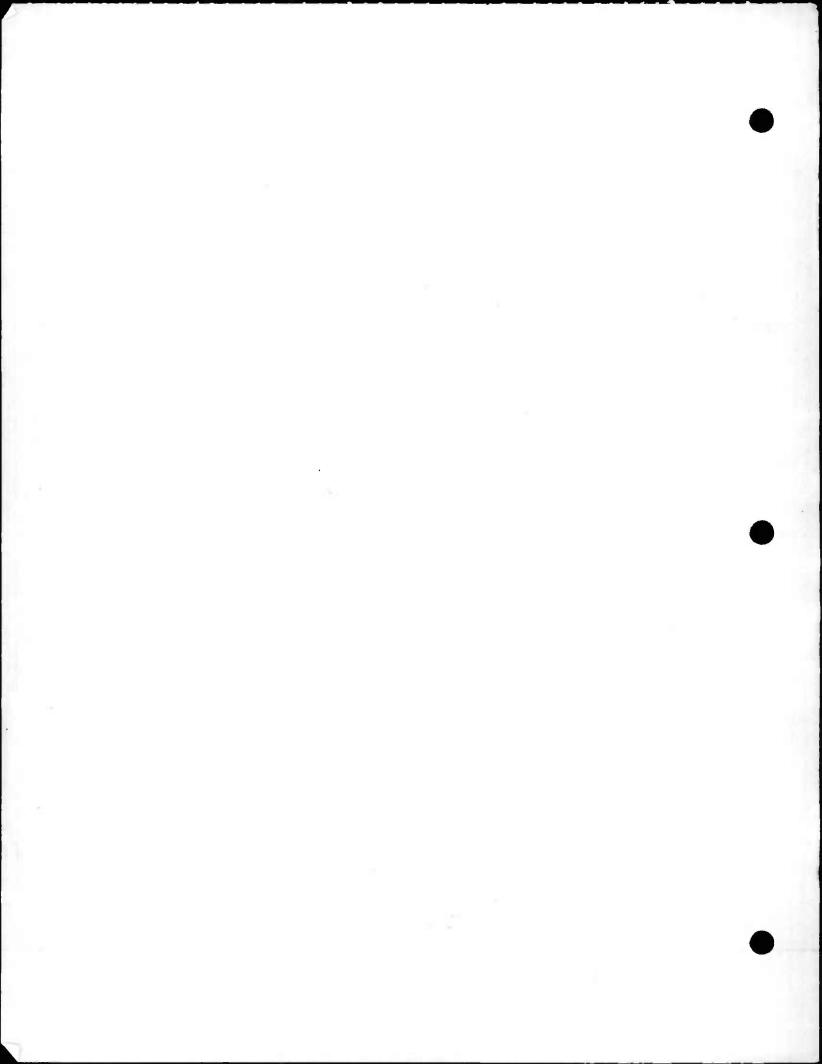


<b>MARYLAND 21215-0020</b>	al or attending physician.
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BALTIMORE, I	death
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DIVISION OF VITAL RECORDS, P.O. BOX 68760.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - FOR STATE REGISTRAR	STATE OF MARYL		ENT OF HEALTI		NTAL HYGIENI REG. NO.	E			
		enice F	R. PAid	IE.	2	DATE OF OEATH DA	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER  218-78-4990  9e. FACILITY NAME (If not institution, give stree	66 YRS. MO	MONTHS DAYS HOURS MIN. SEPT. 25, 1928				8. BIRTHPLACE (State or Foreign Country) 8 SOUTH CAROLINA COUNTY OF DEATN			
TOR	BON SECOURS HOSPIT	-	BALTIMORE		N	N/A				
DIRECTOR	MARYLAND 106. COUNTY	10c. CITY, TO	BALTIMORE	CITY			10d. INSIDE CITY LIMITS? 1 X YES 2 NO			
FUNERAL	3403 GWYNNS FALL:		10f. ZIP CO	21216		WHAT COUNTRY?				
B	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 🔯 Divorced	U.S. ARMED 2 X NO NTES	13. WAS DECENDENT If yes, specify Cul 1 ☐ YES 2 ☐ WHO	an, Maxicen, F	ORIGIN? (Specify Yee Puerto Rican, etc.)	e or No— 14. RACE — American Indien, Black, White, atc. Specify: BLACK				
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementery/Secondery (0-12) 4th GRADE	TON mpleted) College (1-4 or 5 +)	(Give kind of work life. Do NOT use re-	ECEDENT'S USUAL OCCUPATION Give kind of work done during most of working to NOT use retired.) MEAT PACKER			16b. KIND OF BUSINESS/INDUSTRY  MEAT PACKING COMPAN			
BE COM	17. FATHER'S NAME (First, Middle, Last)  JAMES	111111111111111111111111111111111111111	18. MO	THER'S NAME IMA	(First, Middle, Melden					
2		OGERS		WYNNS FAL				RYLAND 21216		
	20a METNOD OF DISPOSITION 1A Burlat 2 Cremation 3 Remova 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEN	I from Stata Cem	PLACE AND DATE OF D etery, cremetory or other p RBUTUS MEM	place)		2-95 ARB	UTUS, MAI			
	Chal	0	Bn.	JOSEPH H 1913 W.	. BROWI	N JR FUNE ORE ST.,	BALTIMO	E,P.A. RE, MD.21223		
	23. PART I. Enter the diseases, or conshock, or heart fellure. Lis IMMEDIATE CAUSE (Final disease or condition resulting in dasth)	t only one ceuse on ea	ich fine.	LAO CL		a cardiac or reapi	ratory arreat,	Approximate interval Between Onset and Death		
CERTIFICATION	Sequentially liet conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in daeth) LAST  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.									
Ŋ.	PART II. Other significent conditione contributing to death but not resulting in the underlying ceuse given in Part i.  24a. WAS AN AUTOPSY PERFORMED?  1 YES 2 00  24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO									
ICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)  EXAMINER?  HOSPITAL:									
BY PHYSI	1 VES 2 NO 1  27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28b. TIME OF	Nursing Home   5   Residence   8   Other (Specify)			JURY OCCURED				
	3 Suicide 6 Could not be datarmined	28e. PLACE OF INJURY building, etc. (Speci	— At home, farm, stree fy)	ome, ferm, street, factory, office			281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
COMPLETED	29e. CERTIFIER (Check only one)  2 MEDICAL EXAMINER: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(e) and menner as stated.  2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated.									
IO BE	296. SIGNATURE AND TITLE OF CERTIFIER  ALCHUMEN  A. Cum M.D. 296. LICENSE NUMBER  DZSY8  296. DATE SIGNED (Month, Day, Year)  + 4/25/95									
	30. NAME AND ADDRESS OF PERSON WHO C Leduvina L. C			Harford	Road	Balto	MD 2	1214		
	31. DATE FILED (NORTH 1995 AL	32 TOIS TARIS OF			_					



-transit permit. Pages 1, 2, 3 should

BALTIMORE, MARYLAND

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be manned by the attending physician and completely filled in by the funeral director, page 5 should be denote to filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Nem 28 is marked, or Nem 23 shows any Injury, or other traumatic event, the medical examiner must be metitled at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

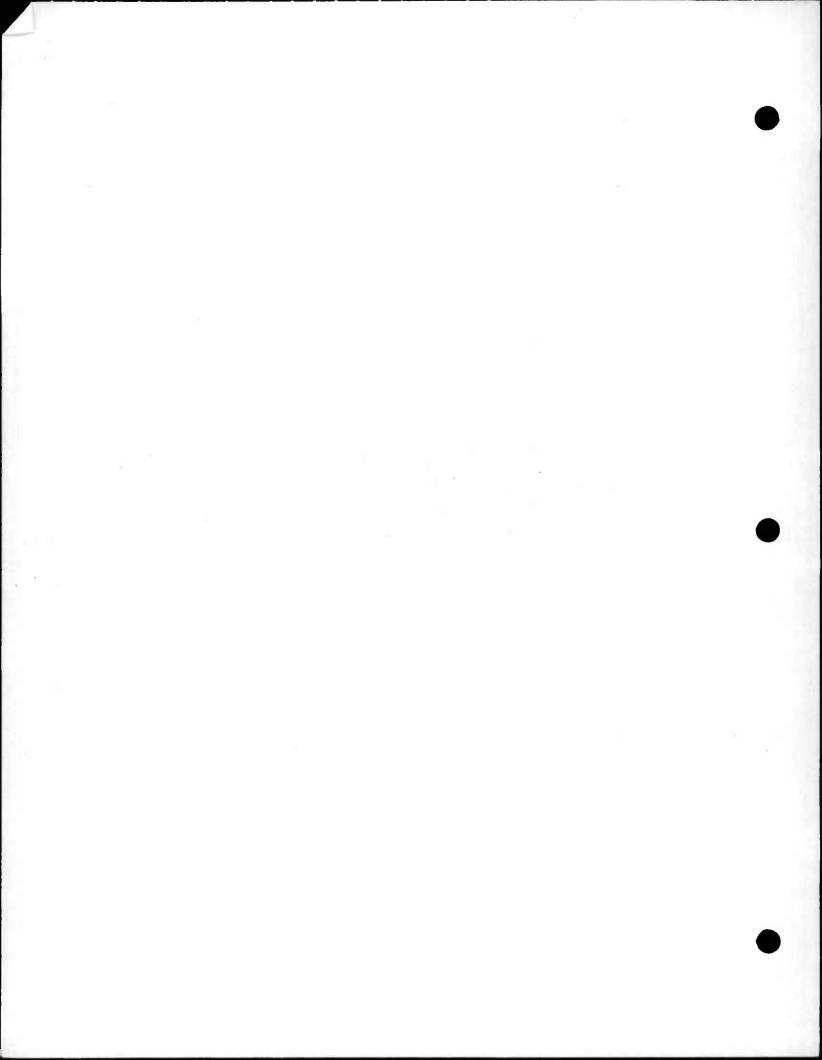
1. DECEDENT'S NAME (First	, Middle, Last)									2. DATE OF	OEATH			3. TIME OF DEATH
CELSA S.	PERTUSA	TTI								MONTH DAY YEAR 9:47				9:47 A. M
4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (I	n yrs. lesi	birthday)	IF UNDER		1	IF UNDER 24 HRS. 7. DATE OF BIRTH			8. BIRTHPLACE (State or Forei		
147-70-2339		1 M 2 F		83	YRS.	MONTHS	DAYS	HOURS	MIN.				ARGE	ENTINA
Sa. FACILITY NAME (If not in						9b. CITY		OR LOCATI	ON OF DE	EATH 9c.			INTY OF D	
LAUREL REGION		PITAL					LAUREL				PRINCE GE			DE GEROGE
10a. STATE	10b. COUNT	1			10c. CITY	, TOWN (	OR LOCA	TION						10d, INSIDE CITY
MARYLAND		HOWARD			LAUREL									LIMITS?
10e. STREET AND NUMBER							10	f. ZIP COD	E .	<del></del>		10a. CIT	ZEN OF V	VHAT COUNTRY?
9446 GLEN RIS	OGE DRIV	/E							20723	3				ENTINA
11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN	U.S. ARI	MED	13.	WAS DE	CENDENT C	F HISPAN	IIC DRIGIN? (S	pecify Yee	or No-	14. RACE	E — American Indien,
1 Never Married 2 1 3 Widowed 4 Divo		FORCES? 1 IF YES, GIVE V	WAR DR DA	TES N	0			secify Cuba		n, Puerto Rica	n, etc.)		Speci	k, White, etc.
								ARGEN	TIAN				-HI SF	PANIC White
(Specify only	EDENT'S EDU			(Gh	CEDENT'S I ve kind of w Do NOT use	rork done	CCUPATE during mo	ON ost of working	g	16b. KIR	OF BUS	INESS/IN	DUSTRY	
Elementary/Secondary (0	l-12)	College (1-4 or 5	+)		OMEMA						Ho	ME		
17. FATHER'S NAME (First, M	iddle, Last)	<u> </u>			OFILITA	KLIK	_	18 MOT	ED'C NA	ME (First, Midd				
LORENZO SANCI	HES							ľ	TIDA		e, Maloen	sumame)		
19. INFORMANT'S NAME (7	ype/Print)			19b	MAILIND	ADDRESS	S (Street o			Route Number, (	City or Town	State Zi	n Codel	
MIRTHA HAVILA	AND			- 1						JREL, MA				
20a. METHOD OF DISPOSITE 1 ☐ Burlel 2 ☑ Crematio		mmi from State			NDDATED		SITION (N	ame of		DATE	20c. LO	CATION —	City or To	wn, State
4 Donetion 5 Ciber	(Specify)		- BA	LTIMO	RE WA	her place) SHINC	TON	CREMAT	ORY	4/30	LAU	REL,	MARYLA	AND
21. SIGNATURE OF FUNERA	L SERVICE CIC	ENSEE	) /			22.		ND ADDRES		1 -	ECK F	UNERA	L HOME	E, INC.
<b>▶</b> X G	Val	Yeur	lab	5						RING ROA	D, LA	UREL,	MARYL	LÁND 20707
23. PART I. Enter the di shock, or he	sesses, or o	omplications the	t coused	strip des	th. Do n	ot enter	the mo	ode of dyl	ng, suci	h aa cardisc	or respin	ratory ar	reat,	Approximate
IMMEDIATE CAUSE (FIR		7	5	Y.	1									Onsat and Death
disease or condition	<b>+</b>	me	Has	8004	KC)	COL	LOW	ca	MC	20				16 mas
		DUE TO	(OR AS A	CONSEQ	UENCE DF	):								
Sequentially list conditi	one T	b												
If any, leading to Immed cause. Enter UNDERLYI	diate	DUE TO	(OR AS A	CONSED	UENCE OF	):								
CAUSE (Disesse or Inju		DUE TO	(DR AS A	CONSEC	HENCE OF	١.								
that initiated events resulting in death) LAS	т .	502.15	(OTI NO N	CONSEC	OLNOL OF	,.								i i
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PART II. Other algnifica	nt condition	contributing to	death bu	t not re	sulting in	the un	deriyin	g cause g	iven in	Part I. 24s	. WAS AN /		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
	Pe	pelcen	ua							_   10	YES 2	/		COMPLETION OF CAUSE OF DEATH?
		~							5			1		1 TYES 2 ND
DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF	DEAT	H YE	1 🗆 2	NO [	UNC	ERTAIN	液				
25. WAS CASE REFERRED 11 EXAMINER?	MEOICAL.	NOSPITAL:	2	6. PLACE	OF DEAT	H (Check			/					
1 TES NO		1 inputient 2	ER/Outpe	tient 3				e 5 🗆 Re	aldence	8 Other (Sp	ecify)		′	
27. MANNER OF DEATH	Dandina	28e. DATE OF (Month, D			286. TIME	DF JRY	28c. INJ WC	URY AT		28d. DESCRI	BE HOW IN	JURY OC	CURED	
	Pending Investigation					М		YES 2	ND					
	Could not be	28e. PLACE D building,	etc. (Specif	— At hon (y)	ne, term, at	reet, tect	ory, offic	•		28f. LOCATID City or To	N (Street ei wn, State)	nd Number	or Rural Ru	oute Number,
-/-														
		CIAN: To the best of												
MEDI	CAL EXAMINE	R: On the basis of e	cemination	end/or in	restigation	, in my o	pinion, d	leath occur	ed at the t	time, date end	plece, end	due to th	e ceuse(a)	and manner as stated.
296. NGNATURE AND TITLE	OF CERTIFIER	14.						OC. LICE	NSE NUN	BER ?		29d. DAT	E SCHED	Minter My Hours
OMMU	XXX	w	7					Do	-54	47		▶ 4	D	190
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BALTIMORE, MARYLAND 21215-0020	nours after death. Page 6 may be retained by the hospital or attending physician.
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DIVISION OF VITAL RECORDS, P.O. BOX 687

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Oppt, of Health and Mental Hygiene prior to burial, cremation, or removal.  IMPORTANT: It item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF HEALTH	AND ME	NTAL HYGIENE		
	1. DECEDENT'S NAME (First, Middle, Lest)					DATE OF DEATH DAY		3. TIME OF DEATH
	Maureen Ann Powers					oril 25, 199	YEAR 5	8:30 A. M
	4. SOCIAL SECURITY NUMBER	1000000		F UNDER 1 YEAR F UNDER	R 24 HRS. 7.	DATE OF BIRTH (Month, Day, Year)	8. BIRT	NPLACE (State or Foreign
	038-24-9725	1 🗆 M 2 💢 F	56 YRS.		De	ecember 11,		ode Island
nc	Se. FACILITY NAME (If not institution, give t			b. CITY, TOWN OR LOCAT	ION OF DEATN		9c. COUNTY OF	DEATN
DIRECTOR	13137 Larchdale Road	<u> </u>		Laurel			Prince	George
<u> </u>	10e. STATE 10b. COUNT	Υ	10c, CITY,	TOWN OR LOCATION				10d. INSIDE CITY
ā	Maryland Pri	ince George		Laurel				LIMITS?
¥	10e. STREET AND NUMBER			10f. ZIP COE	DE		10g. CITIZEN OF	WHAT COUNTRY?
FUNERAL	13137 Larchdale Road	#7		2	0708		l	JSA
5	11. MARITAL STATUS  1 Never Married 2 Nerried	12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS DECENDENT If yes, specify Cub	OF NISPANIC C	ORIGIN? (Specify Yes o		CE — American Indian, ck, White, etc.
BY	3 Widowed 4 Divorced	IF YES, DIVE WAR OR D		1 TYES 2 NO		and the angle of co.	Spe	
	15. DECEDENT'S EOU	CATION	16a. DECEDENT'S US	UAL OCCUPATION		166. KIND OF BUSIN	JESS (INDI ISTRY	
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of wor life. Do NOT use i	k done during most of work	ing	log King of Bosin	COS/MOUSTRY	
鱼	12		LPN			Medical		
8	17. FATHER'S NAME (First, Middle, Last)			18. MOT	HER'S NAME (	First, Middle, Maiden Su	imame)	
BE	Ronald Aylward			Sa	rah A. F	leming		
0	19e. INFORMANT'S NAME (Type/Print)			DRESS (Street and Number	or Rural Route	Number, City or Town,	State, Zip Code)	
-	Patricia A. Earley		252 E1		Laurel	Mary	land	20724
li	20a, METNOD OF DISPOSITION  1 X Burlel 2 Cremation 3 Rem	oval from State CON	D. PLACE AND DATE OF I	plece)			TION — City or T	own, State
	4 Donation 5 Other (Specify)		adowridge Me	emorial Park 22. NAME AND ADORE			ey, Maryl	and
	· / Du	Tood of how	6			' Fleck Fu Road, Laur	neral Hom	ne, Inc.
-	22 DART I FOUNDATION	en my	all				_	and 20707
		List only one cause on a	mab line	anter tha mode of dy	ring, auch aa	cerdiac or reapira	tory arreat,	Approximata Interval Batween
	IMMEDIATE CAUSE (Finel disease or condition	\ '	1	00.0		0.		Onset and Death
	reaulting in death)	a. DUE TO (OR AS /	CONSEQUENCE OF:	canan	ملا د	sociena	que	6403.
2			,				0	
일	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):					
S	cause. Enter UNDERLYING CAUSE (Disease or injury	G						
E	that initiated events reaulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):					
CERTIFICATION		d						
CAL	PART il. Other algnificent condition	a contributing to deeth b	ut not resulting in	the underlying cause	given in Part	i. 24s. WAS AN AU		. WERE AUTOPSY FINDINGS
임						1 TES 2	No	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDI								1 TES 2 NO
ä	DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	F DEATH YES	□ NO □ UNO	CERTAIN [			
Ö	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF DEATH	Check only one) THER:				
IYS	1 YES 2 NO  27. MANNER OF DEATH	1 Inpatient 2 XER/Outp	atlent 3 DOA 4	☐ Nursing Nome 5 ☐ R				
	Natural 5 Pending	(Month, Day, Year)	28b. TIME O	Y WORK?		I. DEŞCRIBE HOW INJI	URY OCCURED	
BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY	— At home farm etre	M 1 YES 2		LOCATION (Street and	Montan of Dord	2
COMPLETED	4 Homicide 8 Could not be	building, etc. (Spec	sify)	ot, ractory, office	201.	. LOCATION (Street and City or Town, State)	Number of Hural	Houle Number,
9	29e. CERTIFIER CERTIFYING PHYSI	CIAN: To the heat of my know	lades death assumed		25.5 E.S		-3-13	
M		CIAN: To the best of my know R: On the basis of examination						e) and manner on stated
- 11	29b, SIGNATURE AND TITLE OF CERTIFIER							- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1
H	L whenha &	. U100+c	_	2	ENSE NUMBER	マ   [*]	DATE SIONES	(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE			0	· · ·		-/12
	* WHEID WE	as Iss	2 X100	way ct	4 %	Keenle	UMM	10
	MAY 0 2 1995	32. GIST AB'S	W.K		-		20.	770
	INMI OF 1999							



	1 - STATE REGISTRAR	SIMIE OF M	CE		ICATE C			MENIAL HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Lest)							2. DATE OF OEATH	DAY	WFAB.	3. TIME OF DEATH
	JAMES	W.			PFAE	NDTNE	1R	APRIL	23	95	1:50 A.m
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. last		IF UNDER 1 YE		TR 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTI	IPLACE (State or Foreign
	377-44-4759  9e. FACILITY NAME (If not institution, give str	1 M 2   F	50	YRS.					1945		CHIGAN
DIRECTOR	NORTH ARUNDEL H					POLIS		EN BURNIE		NE A	ARUNDEL
EC	10a. STATE 10b. COUNTY	-		10c. CIT	TY, TOWN OR LO	CATION					10d. INSIDE CITY
	MARYLAND	ANNE ARUI	NDEL		LAURE	L					LIMITS?
AL	10e. STREET AND NUMBER					101. ZIP COD	DE		10g. CIT	IZEN OF	WHAT COUNTRY?
FUNERAL	3373 CRANBERRY SO					21	0724			Ţ	JSA
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [ IF YES, GIVE WA	EVER IN U.S. ARI	MED IO	If yes	DECENDENT ( b, specify Cubic YES 2 NO	en, Mexica	NIC ORIGIN? (Specify Yean, Puerto Ricen, etc.) fy:	a or No—	Blac	E — American Indian, k, White, etc. tty: WHITE
	15. OECEDENT'S EDUC. (Specify only highest grade of	ATION completed)	18a. OE(	CEDENT'S	S USUAL OCCUP work done during	ATION	ring	16b. KINO OF BU	JSINESS/INC	DUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life	. Do NOT ut	ise retired.)		ing	110 00		CESTON.	
ĕ	12 10			MAII	HEMATIC			US GO		1ENT	
Ö	WALTER JAMES PFAE	NDTNER						AME (First, Middle, Maider N R. MUZZY			
B	19e. INFORMANT'S NAME (Type/Print)	NDINLK	198	MAILING	ADDRESS (Str			Route Number, City or Tox		- On dal	
2	ANNEGRET R. PFAEN	DTNER						House Number, City or You H, LAUREL,			20724
1	20a. METHOD OF DISPOSITION			AND OATE	OF DISPOSITION				OCATION —		
	1 Buriel 2 Cremetion 3 Remote 4 Donation 5 Other (Specify)		ROSELA	and I	PARK			4/28 BE	RKLEY	, MI	
1	21. SIGNATURE OF FUNERAL SERVICE LICE	PISEE			22. NAM	AND AOORE	SS OF FA	CILITY FLECK			
	X VICT	( )	Ged	_				PRING ROAD			
	23. PART I. Enter the diseases, or co	omplications that	caused the day	ath. Do	not antar tha	moda of dy	Ing, auc	h as cardiac or resp	iratory arr	rest,	Approximate
	shock, or heart failure. L IMMEDIATE CAUSE (Final disease or condition resulting in death)	. Arter	se on each line. rioscler	otic	- un			du dis			Interval Between Onset and Death
		DUE TO (	(OR AS A CONSEQ	UENCE OF	F):			1000000			
CERTIFICATION	Sequentially list conditions,	OUE TO (	OR AS A CONSEQ	DUENCE O	FI:						
CAT	If any, laading to immediata cause. Enter UNDERLYING				. ,,						Ì
H	CAUSE (Disease or Injury that Initiated events	OUE TO (	OR AS A CONSEC	VENCE O	F):						
ERT	resulting in death) LAST	l									
	PART II. Other significant conditions	contributing to	death but not n	eaulting	In the undari	vina cause	given in	Part I. 24s. WAS AN	ALITOPSY	1 246	WERE AUTOPSY FINDINGS
DICAL		· Continue				in B occor	given	PERFO	RMED?		AMILABLE PRIOR TO COMPLETION OF CAUSE
W								1 X YES	} ∐ NO		OF DEATH?
2	DID TOBACCO USE CONTR	IBUTE TO CAL	JSE OF DEAT	TH Y	ES   NO	□ UNC	CERTAIN	$\square$			1 XYES 2 NO
PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL				TH (Check only o		-				
/SIC	V	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER: 4 - Nursing I	fome 5 🗆 R	ealdence	8 Other (Specify)			
H	27. MANNER OF DEATH	28e. DATE OF II (Month, Day	INJURY IV. Year)	28b. TIM INJ	E OF 28c.	INJURY AT WORK?		28d. DESCRIBE HOW	INJURY OCC	CURED	
B	1 Netural 5 Pending 2 Accident Investigation				M 1	YES 2	_ NO				
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF building, e	FINJURY — At homete. (Specify)	ne, term, e	atreet, fectory, c	ffice		261. LOCATION (Street City or Town, State)	end Number )	or Rural F	Route Number,
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSICI (Check only one) 2 MEDICAL EXAMINER.	IAN: To the beet of m	ny knowledge, dea amination end/or ir	ith occurre	ed at the time, o	iste end place n, death occu	i, end due	to the ceuse(a) and ma	nner as stat	led. ie cause(a	) and manner ea stated.
BEC	29b. SIGNATURE AND TITLE OF CERTIFIER					29c. LIC	ENSE NUM	MBER	29d. DAT	E SIGNED	(Month, Day, Year)
면 연	Wonald & W	right M	-			0.0	C.M.	Ε.	▶ A	PRI	L 23,1995
F	30. NAME AND ADDRESS OF PERSON WHO										
	DONALD G. WRIG				enn S	treet	. В	altimore	, Ma	ryl	and 21201
	31. DATE FMOAY 10 02 1995	RUA WALL	R'S SIGNATURE	4							

DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

02 1995

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

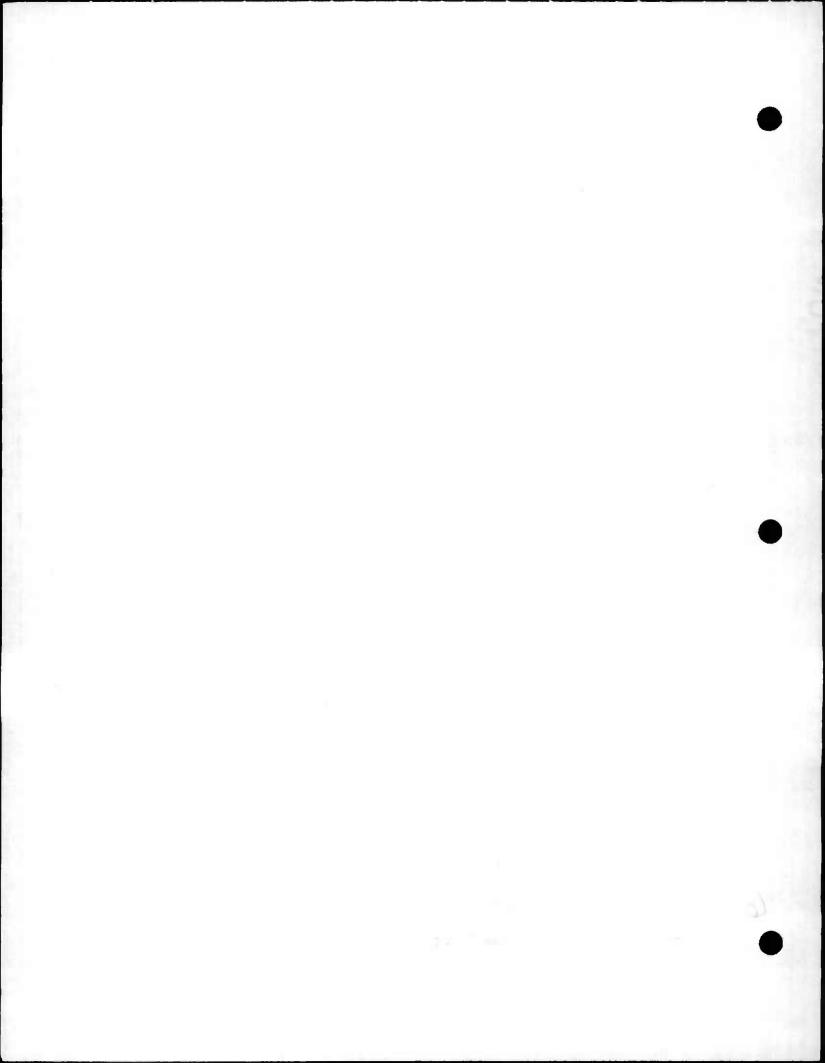
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicial	JIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-r		
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		1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND /		RTMENT				MENTA	NL HYGIEN REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)	LILL	IAN M.		-				2. DAT	E OF DEATH		YEAR 3	TIME OF DEATH
		4. SOCIAL SECURITY NUMBER 213-07-3827	5. SEX 1 M 2 F	6. AGE (In yrs. les	birthday) YRS.		YEAR DAYS	IF UNDER	MIN.	7. DATE	25-188		9. BIRTHPL Country 1ARYI	ACE (State or Foreign
. 3 should	E C	90. FACILITY NAME (If not institution, give a HERITAGE N. H.	street and number)			9ь. Сіту,		DR LOCATI	ION OF DE			9c. COUN	TY OF DEA	ГН
jes 1, 2,	DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNT			10c. CIT	TY, TOWN OF								id. INSIDE CITY
mit. Pag		MARYLAND BAL	TIMORE		NT.	POI	-						2	LIMITS?
physician. burial-transit permit. Pages	FUNERAL	7568 NEW BATTL						1. ZIP COD 1. 2.2.2				USA		T COUNTRY?
the the	ВУ	11. MARITAL STATUS 1 Never Merried 2 Merried 3 W Widowed 4 Divorced	12. WAS DECEOEN FORCES? 1 IF YES, GIVE V	T EVER IN U.S. AR YES 2 XI WAR OR DATES	IMED NO	14	yes, sp	ENOENT Cobe	ın, Mexica	n, Puerto	N? (Specify Yes Rican, etc.)	or No-	14. RACE - Black, V	American Indian, thite, atc.
6 2	ETED	15. DECEDENT'S EDU (Specify only highest grade	completed)	(G	ive kind of	Work done du	CUPATIO	ON ist of worki	ng	16	b. KIND OF BUS	SINESS/INDI	USTRY	
hospiti ached	COMPL	12 YEARS	College (1-4 or 5	" HOM	EMAK	ER					WN HON			
8 8 8	BE CC	17. FATHER'S NAME (First, Middle, Last) AUGUST F. WEIS						ELI	ZAB	ETH	Middle, Maiden MIYT2	ZELĹ		
y be retained thage 5 should be notified	TO E	1994. INFORMANT'S NAME (Type/Print) MRS. L. KERSTE	TTER	7.	568	NEW	BA'.	rd Number	GR	OVE	RD. I	n, Stete, Zip BALT(	O. MI	21222
e 6 ma ector, p		20s. METHOD OF DISPOSITION 1X Burlel 2 Cremetion 3 Rem 4 Donetion 8 Other (Specify)		20b. PLACE		OF OISPOSIT				5-			Ity or Town	State 21224
- 9 7		Marles R. Ad	osoros	uski		120	1 I	DUND	ALK	AV	ERAL H	LTO.		21222
within 24 hours at applietely filled in by cremation, or remover, the medic		23. PART I. Enter the diseases, or shock, or heert failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a.	t caused the de an each line SSU (OR AS A CONSE	la 1	Acul	he mo	da of dy	ing, suci	n aa car	disc or respi	ratory arre	est,	Approximats Interval Between Onset and Death
te be execu sician and prior to bur traumatic	RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury		(OR AS A CONSEC	DUENCE O	Seve F):	lef							2-3/
death certifical attending phy ental Hygiene iry, or other	CERTIF	that initiated eventa reaulting in deeth) LAST	DUE 10	(OR AS A CONSEC	DUENCE O	F):								
that the led by the th and M any inju	MEDICAL	PART II. Other aignificant condition	s contributing to	death but not r	esuiting	in the und	eriying	cause (	given in	Part i.	24a. WAS AN A PERFOR	MED?	AM CC	RE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE OEATH?
sh of	: ME	DID TOBACCO USE CONTI	PIRLITE TO CA	LISE OF DEA	TH Y	ES 🗆 NI	∩ Ď	LING	ERTAIN			9		YES 2 NO
has has	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			TH (Check on	_	0140	EKIAII	• LJ				
SICIAN: The certificate the state d, or item	HYS	1 TYES 2 AO	1 Inpatient 2 I	INJURY	28b. TIM	4 Nursir	8c. INJ	URY AT	esidence		SCRIBE HOW IN	JURY OCC	URED	
DING PHYSII After this codeath with t	ВУ	1 Natural 5 Pending 2 Accident Investigation	(Month, D.			M	1 🗌 Y	RK7 YES 2	ON					
OR ATTENDING DIRECTOR: After hours after death	ETED	3 Suicide 8 Could not be 4 Homicide determined	building,	F INJURY — At ho etc. (Specify)	ma, tarm, :	street, tector	y, office			281. LOC	CATION (Street a or Town, State)	nd Number o	or Rural Rout	Number,
世世紀=	COMPLETED	29e. CERTIFIER (Check only one)  2 MEDICAL EXAMINE												d menner as stated.
TO THE HOSPI TO THE FUNER be filed within IMPORTANT:	BE	286. SIGNATURE AND TITLE OF CERTIFIES	N	-/				29c, LIC	NSE NUM	BER 2	21	29d. DATE	SIGNED (M	onth, Day, Year)
6	10	30. NAME AND ADDRESS OF PERSON WILL T. A. F. R. M.	O COMPLETED CAUS		1 27) (Type Long	Bor	-7	a	021	221			·/	
•		31. DATE FILEO (Month, Day, Year) MAY 0 2 1995	32. REGISTRA	R'S SIGNATURE										

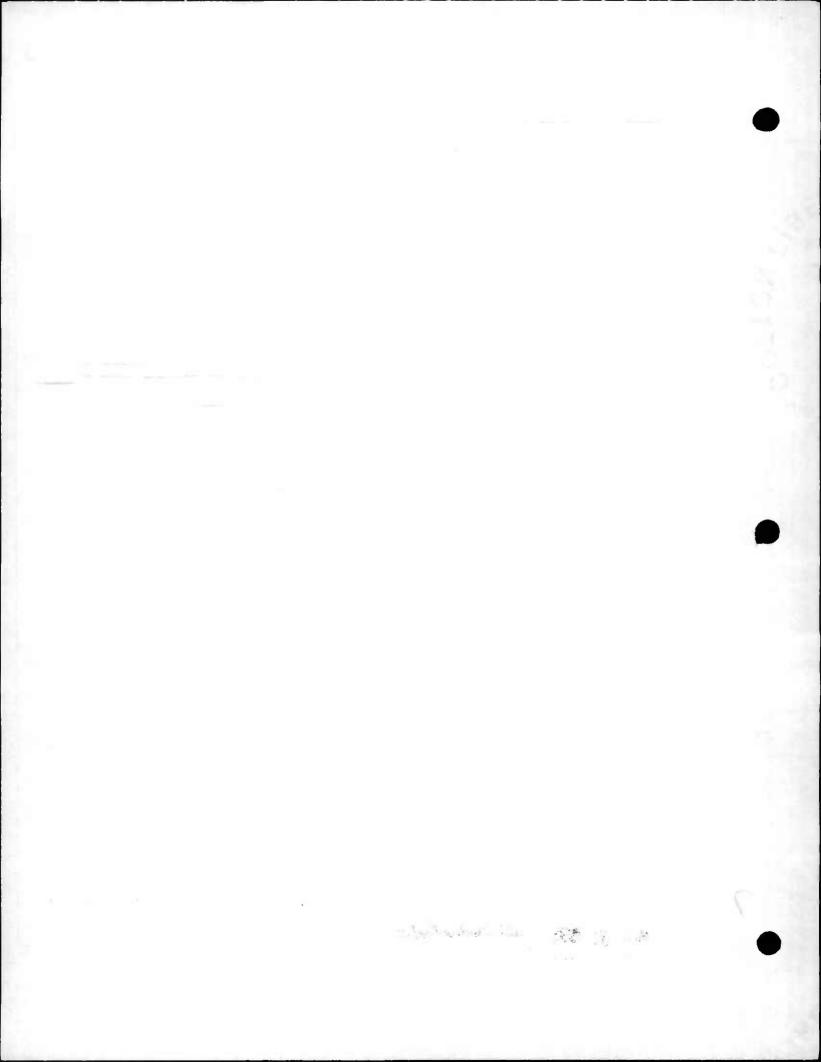


		1 - STATE REGISTRAR	STATE OF MARY	CEI	EPARTMEI	T OF I	HEALTH /	AND MEN	NTAL HYGIE REG. N				
		1. DECEDENT'S NAME (First, Middle, L	5 PAHL	France		nor	Pahl	Ne.	ri 29	Day 1990	VEAR 3.	TIME OF DEATH	
pin		4. SOCIAL SECURITY NUMBER 220-20-1515  98. FACILITY NAME (If not institution, g.	1 - M 2 XF	SE (In yrs. last t	YRS. MONTHS		HOURS	MIN.	Month, Day, Year)	1929	Mary.		1
1, 2, 3 should	TOR	Franklin Square	Hospital				ille	N OF DEATN			MOTE	County	
permit. Pages	DIRECTOR	Maryland Bal	unty timore County	Y	Baltin		ATION					d. INSIDE CITY LIMITS?	
. ist	VERAL	100. STREET AND NUMBER 138 Lyndale Aven	iue				21236				EN OF WHA	T COUNTRY?	
215-0020 attending physician. ise as the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2X Married 3 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2 NO	ED 1:	If yes, s	CENDENT OF pecify Cuban, S 2 🔀 NO	Maxican, Pu	RIGIN? (Specify Yearto Rican, etc.)	1	4. RACE — Black, W Specify	American Indian, hita, atc.	
212-	LETED	15. DECEDENT'S (Specify only highest g Elementary/Secondary (0-12) 12th Grade		(G/ve	EDENT'S USUAL kind of work don to NOT use retired	e durina m	ION lost of working		16b, KIND OF B	USINESS/INDU	STRY		_
MARYLAND 2 retained by the hospital 5 should be detached to notified at once.	COMPLET	17. FATHER'S NAME (First, Middle, Lest) Martin Henry Sch		Ter.	rer				Bank First, Middle, Meide Eleanor				
be retained to ge 5 should re notified	TO BE	19a. INFORMANT'S NAME (Type/Print) William Albert P					and Number o	r Aural Route	Number, City or To	wn, State, Zip (		L236	_
FIMORE, Page 6 may be al director, page		20a. METNOD OF DISPOSITION 1 M Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)		Ob. PLACE AN	D DATE OF DISPO	SITION /N	iame of E /	2 /OF	DATE 20c. L	ocation - co	ty or Town,	State	_
death. death. e funer al.		21. SIGNATURE OF FUNERAL SERVICE	- M. Kuy	nly,	/ J	ohn (	C. Mil Belair	ller,	Inc.	more,	Mary	land 212	06
withing thours at pletely filled in by cremation, or remorement, the medical		23. PART I. Enter the disesses, anock, or heert feilu IMMEDIATE CAUSE (Final disease or condition resulting in death)	or complications that cause re. List only one ceuse on DUE TO (OR AS	each line.					cerdiec or res	piratory arre	nt,	Approximate interval Between Doset and De	
DX 68 be execute clan and co for to buria	CATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING	bDUE TO (OR AS	S A CONSEQU	ENCE OF):								
tending plant Hygiene	ERTIFI	CAUSE (Disease or injury that initiated events resulting in deeth) LAST	DUE TO (OR AS	S A CONSEOU	ENCE OF):								
quires that the n signed by the f Health and M hows any inju	MEDICAL C	PART II. Other significent conditions			1997			ven in Part	i. 24a. WAS A PERFO	N AUTOPSY DRMED? 2 D No	CO OF	RE AUTOPSY FINDIN ILLABLE PRIOR TO MPLETION OF CAUSI DEATH?  YES 2 NO	
S b b w	SICIAN:	DID TOBACCO USE COI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?			OF DEATN (Chec	k only one)		RTAIN [					_
OF VIIA PHYSICIAN: The this certificate h with the State (	PHYSI	1 PES 2 NO 27. MANNER OF DEATN 1 Pending	1 ☐ Inpatient 2 ☐ ER/Os  26a. DATE OF INJURY (Month, Day, Yeer,	Υ :		28c. IN.	JURY AT DRK?		Other (Specify) DESCRIBE NOW	INJURY OCCU	RED		_
	ED BY	2 Accident Investigation 3 Suicide 8 Could not determined	be 28e. PLACE OF INJUI	RY — At home pecify)	, farm, atreet, fa		YES 2	$\rightarrow$	LOCATION (Stree City or Town, State		Rural Route	Number,	_
INA	COMPLET		IYSICIAN: To the beat of my kno									d manner as stated	3
TO THE HOS TO THE FUN DE find with	TO BE CC	29h SIGNATURE AND TITLE OF CERTI	DENTY Modes	EXYW IN	<b>8</b>		29c. LICEN	SE NUMBER				nth, Day, Year)	
10		30. NAME INTO ADDRESS OF PERSON  31. DATE FILED (Month, Day, Ibal)	WIND COMPLETED CAUSE OF B	Jud	Triffype, Print)	v 2)	204						_
		MAY no 1995	John Bludge	x Kardal	4								

Item # 1,18,19b Film # G 723 5-2-95 N.A. Per FuneralHome

	1 - STATE REGISTRAR	STATE OF MARYLA		RTMENT OF		MENTAL HYGIEN REG. NO.		
	DECEDENT'S NAME (First, Middle, Last,     DANIEL RUS     SOCIAL SECURITY NUMBER	SELL Daniel	Clifton-	_	ussell		0, 1995	5 1718 P M
ı	218-29-6438	1 X M 2 □ F	n yrs. last birthday)  4 YRS.	IF UNDER 1 YEAR MONTHS DAYS	# UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 09-01-199(	S. BIR Cou MAR	THPLACE (State or Foreign intry) XYLAND
TOR	9e. FACILITY NAME (If not inatitution, give JOHNS HOPKINS		I.C.U		OR LOCATION OF D		9c. COUNTY OF	
DIRECTOR	10a. STATE 10b. COUNT MARYLAND ANN	E ARUNDEL	10c, C/1	LINTHI				10d. INSIDE CITY LIMITS? 1  YES XX NO
FUNERAL	100. STREET AND NUMBER 307 NORTH HAMMON	IDS FERRY ROAD	1	10	21090			F WHAT COUNTRY?
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMEO 2 XNO TES	If yes, a	CENDENT OF HISPA pocity Cuben, Mexico S 2 NO Specia	NIC ORIGIN? (Specify Yea an, Puerto Rican, atc.) fy:	Bio	ICE — American Indian, ack, White, etc.
APLETED	15. OECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12) PRE SCHOOL	College (1-4 or 5+)	16a. DECEDENT'S (Give kind of life. Do NOT u		ION ost of working		SINESS/INDUSTRY	
BE COMPL	17. FATHER'S NAME (First, Middle, Last)  DORMAN RICHARD R	RUSSELL			307 NO	RTH HAMMON	PS FERRY	
10	19a. INFORMANT'S NAME (Type/Print) DORMAN RICHARD R	RUSSELL	307 N	ORTH HAM	and Number or Rural IMONDS FE	RRY LANE,	n, State, Zip Code) LINTHICU	
H	20e, METHOD OF DISPOSITION 1 LO Burlet 2 Cremation 3 Ref 4 Donation 5 Other (Specify)	movel from State Carpe		OF OISPOSITION (N N MEMORI		17/7/1	CATION — City of EN BURNI	
8	21. SIGNATURE OF FUNERAL SERVICE L	CENSEE Sall	(an)	1 SEC	OND AVEN	OTINGUE.		ERAL HOME,
	23. PART I. Enter tha disesses, Dr ahock, Dr haart feliure IMMEDIATE CAUSE (Final disesse or condition resulting in death)	a. Due to long s A	ch line.		ode of dying, aud	ch as cardiec or respi	ratory arrest,	Approximata Interval Between Onset and Desti
RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	b. DUE TO (OR AS A C. DUE TO (OR AS A						
AL CE	PART II. Other significant condition	ns contributing to death bu	t npt resulting	in the underlyin	ig cause given in			46. WERE AUTOPSY FINDINGS
MEDICA						PERFOR	44	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
PHYSICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL			ES NO TH (Check only one)		N D lugue	ton	
YSIC	1 X YES 2 NO	HOSPITAL:  1X X hpatient 2 - ER/Outpe	itlant 3 DOA	OTHER: 4 - Nursing Hon	ne 5 🗆 Residence	6 Other (Specify)		
ву Рн	27. MANNER OF DEATH  1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year) 4427-195	knKn	oun 1	7	Subject he	nged se	f
ETED	3 Suicide 6 Could not be 4 Homicide detarmined	26a, PLACE OF INJURY - building, atc. (Specific	At home, term,	atreet, tectory, offic	ca	281. LOCATION (Street a City or Town, State)  30 7 North H.	and Humber or Rural	Poute Number,
OMPL		SICIAN: To the best of my knowle ER: On the besis of examination				to the cause(a) and man	Ifter f	Thay land
O BE C	296. SIGNATURE AND TITLE OF CERTIFIE  Theodore M.	Kyy um			O.C.M			1, 1995
_	30. NAME AND ADDRESS OF PERSON WITH THE COORE M. K.	-f 1	11 Pen		et, Bal	timore, M	1arylan	d 21201
- 1	31. DATE FILED (Month, Lay, Year)	32 REGISTRAR'S SIGNA	TURE					

DHMH-16 Rev 1/89



Approximate interval Between Onast and Daath

REG. NO.

FOR STATE REGISTRAR

1, OECEOENT'S NAME (First, Middle, Last)

5 5 3 ¥

	1. OECEOENT'S NAME (First, Middle, Last) He		ffensperger			2. DATE OF DEATH MONTH April 3	3. TIME OF DEATH 6:03 A.	
- 13	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. lest birthday	MONTHS DAYS	IF UNDER 24 HRS	Manual Day 16 - 1	8. B	IRTHPLACE (State or Foreign ountry)
	165-30-5246  9a. FACILITY NAME (If not institution, give		85 YRS.	at ourse mount				Pennsylvania
œ	Greater Baltimo		1 Center		OR LOCATION OF	DEATH	9c. COUNTY C	DF DEATH Baltimore
6	RESIDENCE OF DECEDENT			1011	5011			Daicimole
DIRECTOR	Maryland Bal	r timore	10c, C	TOWSO		-		10d. INSIDE CITY LIMITS? 1  YES 2 NO
UNERAL	100. STREET AND NUMBER 700 Camberley	Circle		1	or. ZIP CODE 21204	4	U.S	OF WHAT COUNTRY?
BY F	11. MARITAL STATUS 1 Never Married 2 Married 2 Widowed 4 Otvorced	FORCES?	NT EVER IN U.S. ARMED I YES 2 NO NAR OR DATES	It yea, o		PANIC ORIGIN? (Specity Victor, Puerto Rican, etc.)		RACE — American Indian, Black, Whita, atc. Specify: White
PLETED	15. DECEDENT'S ED (Specify only highest grac Elementary/Secondary (0-12)		(Give kind o				ate Uni	
E COMPL	17. FATNER'S NAME (First, Middle, Last)  John Irv	in Fahs				NAME (First, Middle, Maide Margaret C	n Sumame)	
TO B	19a. INFORMANT'S NAME (Type/Print) Sharon J. Raffen	sperger	19b. MAILIN 123.	A Dumbar	and Number or Ru ton Road	ral Acute Number, City or To 1, Baltimor	e, Mary	land 21212
	20a. METHOD OF DISPOSITION 1 Surface 2 Cremation 3 Red 4 Donation 5 Other (Specify)	noval from State	20b. PLACE AND DATE cemetery cremetory pr Oak Hil				wanda,	or Town, Stata Pennsylvania
	21. SIGNATURE OF FUNERAL SERVICE L  Wallace		oobs, Is.	Ruck			me, Inc	•
	23. PART I. Enter the disease, or ahock, or haert failure iMMEDIATE CAUSE (Finel disease or condition resulting in death)	List only one car	OF AS A CONSCIUENCE					Approximate interval Betwee Onaet and Day
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	C	OV OVAV (OR AS A CONSEQUENCE	T'·	tery	deleal	<u>e</u>	
EDICAL CE	PART II. Other aignificant condition	na contributing to	death but not resulting	in the underlyi	ng cause given		PRMED?	24b, WERE AUTOPSY FINDING AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATN?
Σ	DID TOBACCO USE CON	RIBUTE TO CA	USE OF DEATH Y	FS   NO	T LINCEPT/	UN E		1 TES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL:		OTHER:	)			
ву РНУ	27. MANNER OF DEATH  1 Naturel 5 Pending 2 Accident Investigation	28a. DATE Of (Month, I)	INJURY 28b, TI	ME OF 28c. IN	JURY AT ORK? YES 2 NO	28d. OESCRIBE NOW	INJURY OCCURED	0
G	3 Suicide 6 Could not be detarmined	28a. PLACE ( building.	OF INJURY — At home, term, etc. (Specify)	atreet, factory, offi	ca	28f. LOCATION (Street City or Town, State	snd Number or Ru	ral Route Number,
Ш	290. CERTIFIER 1 CERTIFYING PHYS	BICIAN: To the best of	my knowledge, death occur	red at the time, dat	and place, and d	lue to the cause(a) and ma	onner en stated	
COMPLET			xamination end/or investigat					

David C. Berliner, M.D. 6565 N. Charles Street, Towson, Md. 21204

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

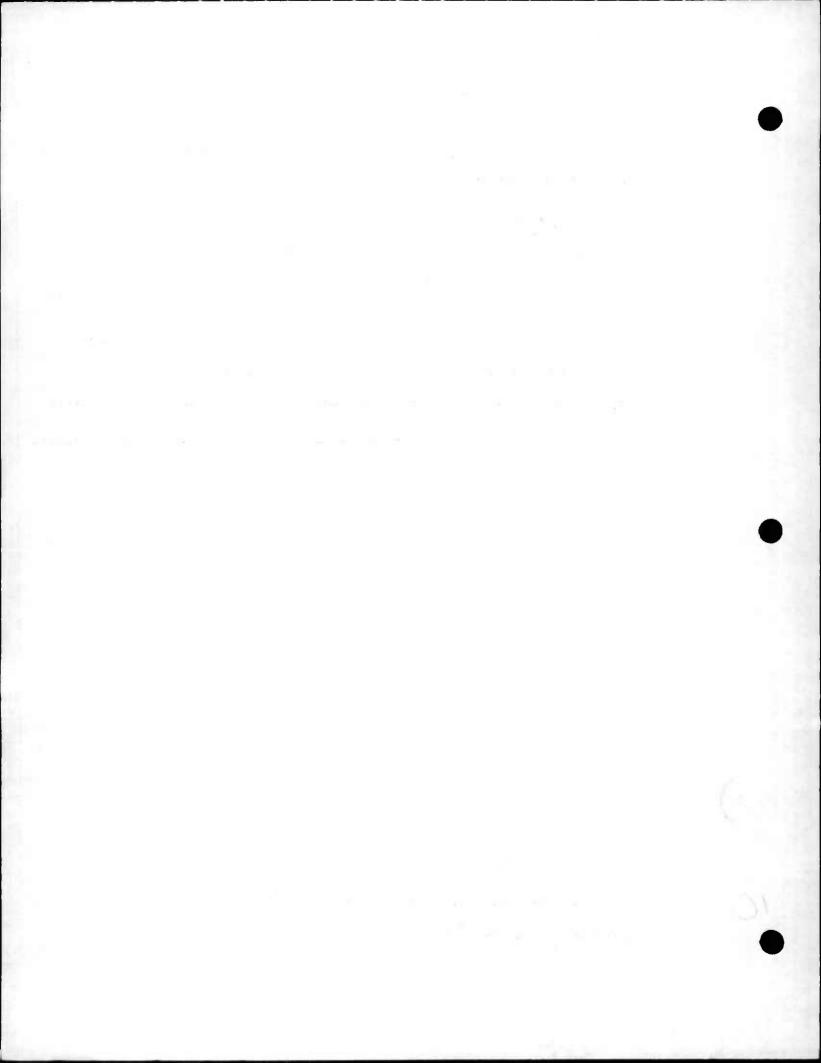
32. REGISTRAR'S SIGNATURE

Devoler Rarball

31. DATE FILEO (Month, Day, Year)

MAY 02 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



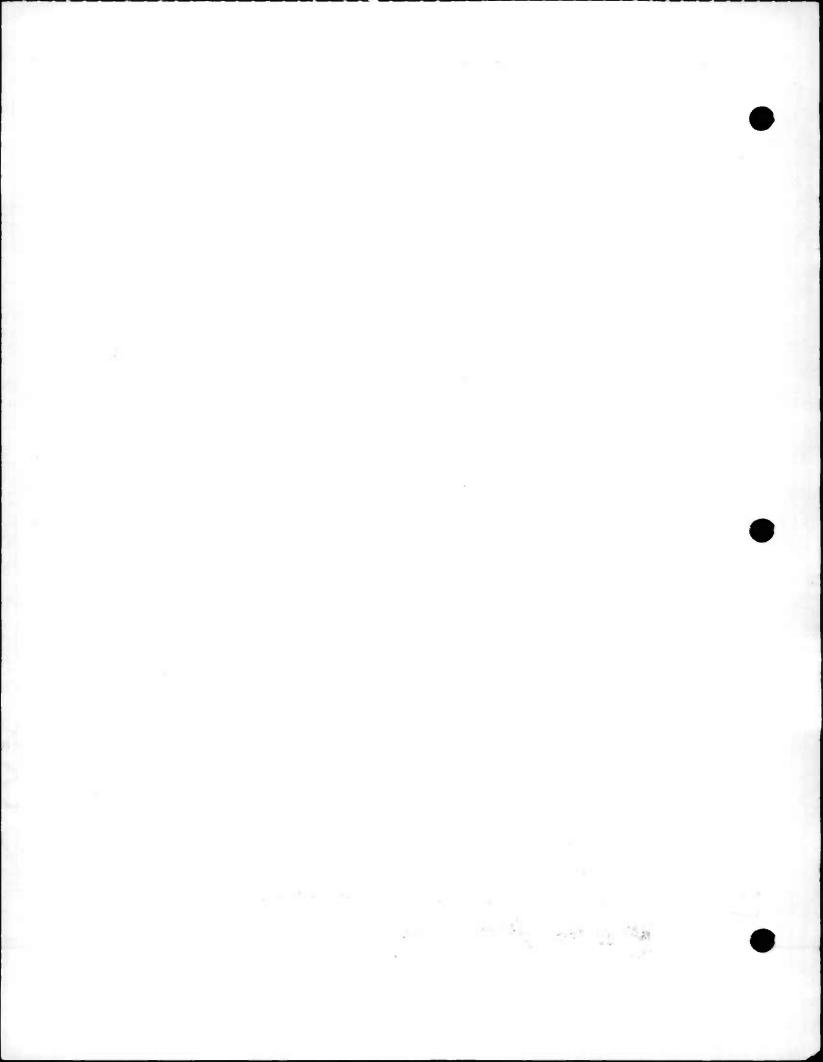
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 EAR Silas Robertson April 26, 1:30 P JR 4, SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign <del>231</del>-36-0532 1 M 2 - F YRS 19**3**8 MD 56 SEPT 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OFATH GENERAL HOSPITAL DIRECTOR Pages 1, 2, 3 BALTO BALTO RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD BALTO BALTO 1 YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 810 N STRICKER ST 21217 burial-transit USA Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuban, Maxican, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married 1 YES 2 X NO Specify: BY Specify: BLACK signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the Heatth and Mental Hygiene prior to burial, cremation, or removal. 3 Widowed 4 Divorced ED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEOENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) ᆸ Elementary/Secondary (0-12) Construction College (1-4 or 5+) 7TH N/A LABORER COMPL 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) G. ROBERTSON SR. ROSA HOCKADAY notified at SILAS BE 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 CHICAGO, RICHMOND AVE ILL 60622 EARL ROBERTSON 851 851 N þe 20a. METHOD OF DISPOSITION

XIX Burlel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of come WITCrematory Disposition). CEM DATE 20c. LOCATION - City or Town, State must 5395 BALTO MD 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY M MARCH F/H-WEST 4300 WABASH AVE lade ane medicai 23. PART i. Enter the diseasee, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or reepiretory arrest, Approximete interval Between shock, or heart feliure. Liet only one cause on each line. IMMEDIATE CAUSE (Final **Onset and Death** the disease or condition Aspiration Pneumonia unknown reaulting in deeth) event. DUE TO (OR AS A CONSEQUENCE OF): other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted eventa resulting in deeth) LAST any injury, PART ii. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 XNO 1 TES 2 NO this certificate has been with the State Dept. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OR ATTENDING PHYSICIAN: The EXAMINER? HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 TES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 10 27, MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 28 is marked, 1 Natural
2 Accident 5 Pending 1 YES 2 NO DIRECTOR: After the hours after death v BY Investigation 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTI be filed within 72 hours at IMPORTANT; If Item 2 29a CERTIFIER 1X CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 89234 BE Darwar 29d. DATE SIGNED (Month, Day, Year) STAFF 1 JOUSE 98 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Shakir Sarwar, M.D. c/o Maryland General Hospital 31, DATE FILED (Month, Day, Year The Devotor Ros

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

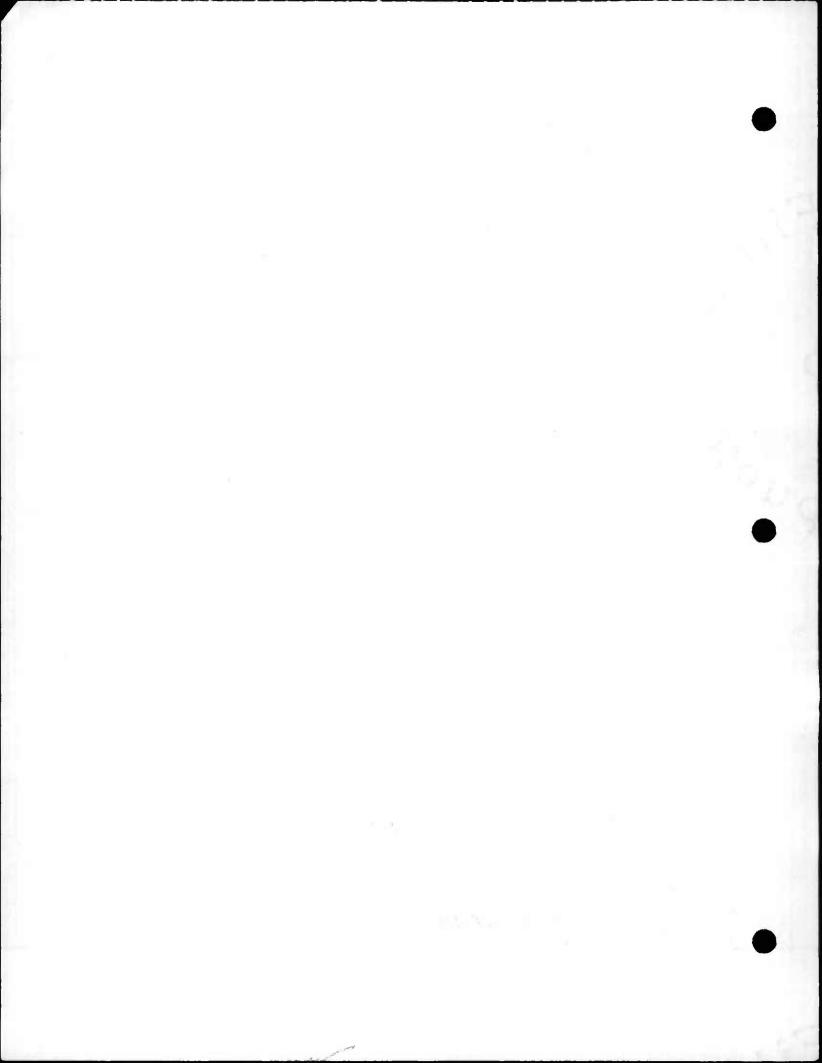


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1 2 should
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

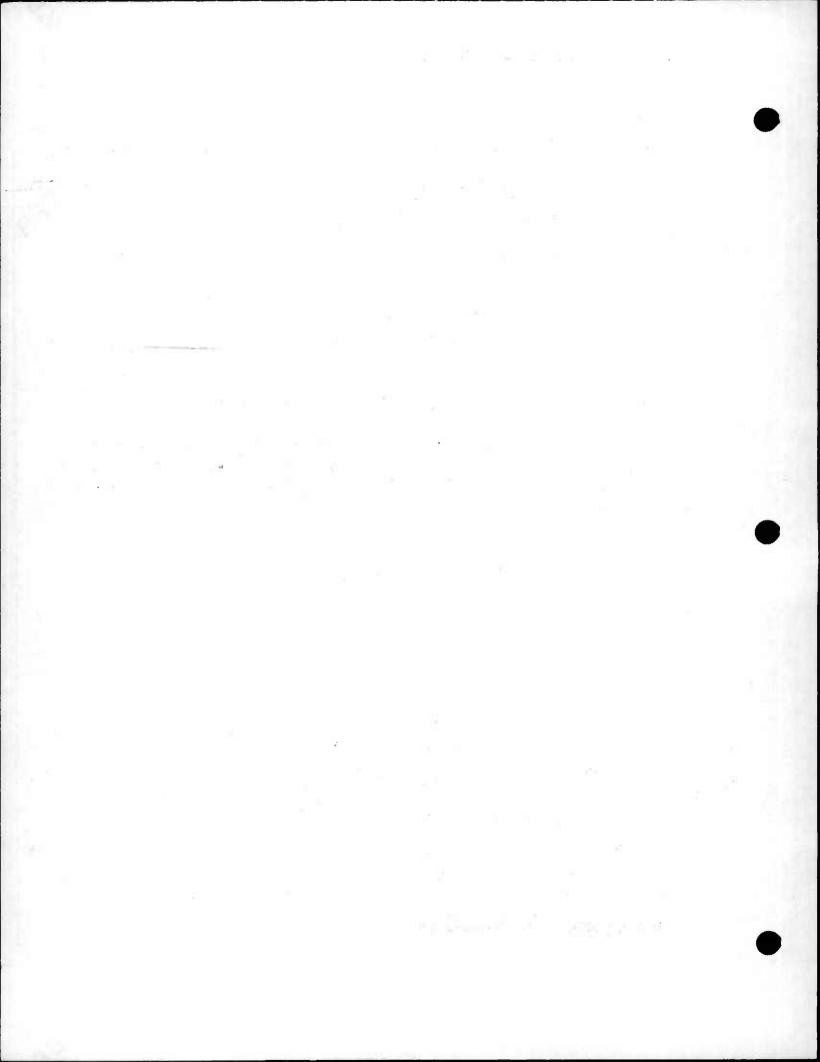
SODHIR,
31. DATE FILED MORTH, DBY, YBAI)
MAY 021995

1. DECEDENT'S NAME (First, Middle, Last)  1. DECEDENT'S NAME (First, Middle, Last)  1. DECEDENT'S NAME (First, Middle, Last)  2. DATE OF DEATH  NONTH  DAY  A SOCIAL SECURITY NUMBER  2.18 - 03 9545  1 M M 2 F  S SEX  6. AGE (In yrs. last birthday)  90. FACILITY NAME (If not institution, give street end number)  Liberty Medical Center  Baltimore  100. CITY, TOWN OR LOCATION  Baltimore	10 71117 05 00 00
TAMES  RAWLINGS  MONTH:  BOY  A SOCIAL SECURITY NUMBER  5. SEX  1. M 2 F S5 YRS.  S5 YRS.  S6. AGE (In yrs. last birthday)  F UNDER 1 YEAR   F UNDER 24 HRS. (Month, Day, Year)  MONTH B DAY  HOURS MIN.  8-30-09  9e. FACILITY NAME (If not institution, give street end number)  9b. CITY, TOWN OR LOCATION OF DEATH  9c. COU	0. THE OF DEATH
4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) F UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year)  90. FACILITY NAME (If not institution, give street end number)  6. AGE (In yrs. last birthday) F UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year)  8 - 30 - 09  90. CITY, TOWN OR LOCATION OF DEATH  9c. COU	3. TIME OF DEATH
218-03 9545 1 M 2 F 85 YRS. MONTHS DAYS HOURS MIN. (Month, Day, Year)  9e. FACILITY NAME (If not institution, give street end number)  9b. CITY, TOWN OR LOCATION OF DEATH  9c. COU	6. BIRTHPLACE (State or Foreign
9e. FACILITY NAME (If not institution, give street end number)  9b. CITY, TOWN OR LOCATION OF DEATH  9c. COU	Country)
Liberty Medical Center Baltimore  RESIDENCE OF DECEDENT  10c. STATE  10c. STATE  10c. CITY, TOWN OR LOCATION	MD INTY OF DEATH
RESIDENCE OF DECEDENT  10c. CITY, TOWN OR LOCATION	n/a
	10d. INSIDE CITY
MD n/a Baltimore	LIMITS?
10e. STREET AND NUMBER 10g. CIT	IZEN OF WHAT COUNTRY?
10e. STREET AND NUMBER  1027 Cathedral St.  11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 1 Yes 2 200 If yee, apecify Cuban, Maxican, Puarto Rican, etc.)	USA
11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARMED  13. WAS DECEMDENT OF HISPANIC ORIGIN? (Specify Yes or No—  16. Never Merried  17. WAS DECEMDENT OF HISPANIC ORIGIN? (Specify Yes or No—  18. WAS DECEMDENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMDENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMDENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMDENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMDENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMDENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMDENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMDENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMDENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMDENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMDENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMDENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No—  19. Was DECEMBENT OR HI	14. RACE — American Indien, Black, White, etc.
3 ☐ Wildowed 4 ☐ Divorced IF YES, GIVE WAR OR DATES 1 ☐ YES 2 ※ MO Specify:	Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed)  16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working	DUSTRY
Elementary/Secondary (0-12) College (1-4 or 5+)  2 vrs. Custodian BAltimo	n = 011 ==
	ore City
17. FATHER'S NAME (First, Middle, Last) Cephas W. Rawlings Wilhelmina Harris 19a. INFORMANT'S NAME (Type/Print) Mildred Distance 9. Janing Ct. Pandallethory	:
19a. INFORMANT'S NAME (Types/Print)  19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zig	
Joan The Ct. Randall Stown, N	MD 21244
20s. METHOD OF DISPOSITION    MX   Duriel   2   Cremetion   3   Removal from State     4   Donation   5   Other (Specify)	
4 Donetton 5 Other (Specify) King Memorial Park 5/4 Woodla	wn, MD
James A. Morton & Sons	Funeral Home
1701 Laurens St. BAlto.	, MD 21217
23. PART I. they the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory and the mode. Do not enter the mode of dying, such as cardiec or respiratory and the mode.	Interval Between
IMMEDIATE CAUSE (Finel disease or condition PALLIETA ANIA WITH SEPKIS	Onset and Death
disease or condition resulting in death)  e. PNUETAENIA WIH SEPSIS  BUE TO (OR AS A CONSEQUENCE-OF):	
1 70	
Sequentielty list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  b. ACVIE 12ENAL FAILUKE,  DUE TO (OR AS A CONSEQUENCE OF):  C.  DUE TO (OR AS A CONSEQUENCE OF):  d.	
CAUSE (Disease Dr Injury DUE TO (OR AS A CONSEDUENCE OF):	
resulting in deeth) LAST	
0	24b. WERE AUTOPSY FINDINGS
SEIZURE DISORDER	AVAILABLE PRIOR TO COMPLETION OF CAUSE
1 VES 2 ANO	OF DEATH?
- YASTRO- TNTESTINAL BLEEDING	
UNCERTAIN □	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DESAMINER?  NO UNCERTAIN DESAMINER?  26. PLACE OF DEATH (Check only one)  EXAMINER?	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DESCRIPTION OF DEATH (Check only one)  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1   Ves 2   No   OTHER: 1   Inpetient 2   ER/Outpatient 3   DOA   4   Nursing Home 5   Residence 8   Other (Specify)	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D  25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1 YES 2 NO OTHER:  1 NO UNCERTAIN D  26. PLACE OF DEATH (Check only one)  THOSPITAL:  1 NOTHER:  4 Nursing Home 5 Residence 8 Other (Specify)  27. MANNER OF DEATH  1 NOTHER:  280. DATE OF INJURY  (Month, Day, Year)  280. TIME OF INJURY  WORK?  280. DESCRIBE HOW INJURY OC	CURED
M 1 YES 2 NO	
2 Accident Investigation M 1 YES 2 NO	
2 Accident Investigation M 1 YES 2 NO	r or Rural Route Number,
2 Accident Investigation M 1 YES 2 NO	r or Rural Route Number,
Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natural   Natu	r or Rural Route Number,
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Accident   2   Accident   3   Suicide   4   Homicide   6   Could not be determined   286. PLACE OF INJURY — At home, farm, atreet, factory, office   286. LOCATION (Street and Number City or Town, State)   29a. CERTIFIER (Check only one)   2   MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, data end place, end due to the time, data end place, end due to the course of the time, data end place, end due to the time, data end place, end due to the course of the time, data end place, end due to the course of the time, data end place, end due to the course of the time, data end place, end due to the course of the time, data end place, end due to the course of the time, data end place, end due to the course of the time, data end place, end due to the course of the time, data end place, end due to the course of the time, data end place, end due to the course of the time, data end place, end due to the course of the time, data end place, end due to the course of the time, data end place, end due to the course of the time, data end place, end due to the course of the time, data end place, end due to the course of the time, data end place, end due to the course of the time, data end place, end due to the course of the time, data end place, end due to the course of the time, data end place, end due to the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of	r or Rural Route Number,  ted.  he cause(a) end manner as stated.  TE SIGNED (Month, Dey, Year)  Pril 3 o 1995

DHMH-16 Rev 1/89



		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	ITMENT OF	HEALTH AND	MENT	AL HYGIENI REG. NO.	E		
		1. DECEDENT'S NAME (First, Middle, Last) ANITA	RABI	NOWITZ			MON	E OF DEATH TH DA	1995	YEAR	3. TIME OF DEATH
pje		4. SOCIAL SECURITY NUMBER 046-24-7068	1 M 2 💢 F 9	yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. OAT	E OF BIRTH			NECTICUT
. 2, 3 should	TOR	90. FACILITY NAME (If not institution, give str MILFORD MANOR NU RESIDENCE OF DECEDENT	·		96. CITY, TOWN	BALTIM			9c. COUNTY OF DEATH BALTIMOR		
it, Pages 1,	DIRECTOR	10e. STATE 10b. COUNTY	BALTIMORE	10c, CIT	Y, TOWN OR LOCA BAL	TIMORE					10d. INSIDE CITY LIMITS?
n. ansit permit.	FUNERAL	100. STREET AND NUMBER 4204 OLD MILFORD	MILL ROAD		101. ZIP CODE 21208			10g. CITIZEN OF WHAT			HAT COUNTRY?
21215-0020  If or attending physician.  For use as the burial-transit	ВУ	11. MARITAL STATUS 1 Never Married 2 Merried 3 Never Married 4 Divorced	12. WAS OECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 XNO	If yes, s	CENOENT OF HISPA pecify Cuban, Mexic S 2 XNO Speci	en, Puerto	IN? (Specify Yee Rican, etc.)	or No— 1	Black,	American Indian, White, etc.
	LETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondery (0-12)	ATION ompleted) College (1-4 or 5+)	16e. DECEDENT'S (Give kind of a life. Do NOT us	USUAL OCCUPATION or done during management of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the c	ION lost of working	16	b. KIND OF BUS		STRY	
AND the hospit detached once.	COMPL	12 17. FATHER'S NAME (First, Middle, Leat)		HEBI	REW TEAC			EDCUM		EDUCA	TION
YLA by the be det	E C		BUFFERD			18. MOTHER'S N.		Middle, Maiden S			
MAR retained 5 should notified	TO BE	190. INFORMANT'S NAME (Type/Print) MRS. BERYL R.GOT		19b. MAILING	ADDRESS (Street	SOSI  end Number or Rural  ROSSING		nber, City or Town		ANSOI MD	_
e 6 may ector, pa		20e_METHOD OF OISPOSITION 1	val from State 20b. F	PLACE AND DATE OF	OF DISPOSITION (N	lame of AMUNO 4	1-28-	TE 20c. LOC	ATION — CI	ty or Town	n, State MD
SALTI r death. P e funeral al. examin		21. SIGNATURE OF FUNERAL SERVICE LICE		200	22. NAME A SOL	LEVINSON	ACILITY V & E	BROS.,	INC.		E, MD 21215
within 24 hours aft notes aft notes aft cremation, or removent, the medical		23. PART i. Enter the disesses, or consher feliume. Limited immediate CAUSE (Finel disease or condition resulting in death)	emplications that caused ist only one cause on eed	ch line.		oda of dying, suc	ch as ce	rdiac or respir	atory srres	st,	Approximate Interval Batween Onset and Death
O. BOX 687  certificate be execute ding physician and co Hygiene prior to buria	CERTIFICATION	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initisted events resulting in death) LAST	DUE TO (OR AS A C								
that the od by the h and M	MEDICAL (	PART ii. Other significant conditions	contributing to deeth but	t not resulting i	in the underlyin	ng cause given in	Pert I.	24a. WAS AN A PERFORM	MED?	0	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
T P P P P		DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YE	S   NO [	UNCERTAI	N $\square$			'	YES 2 NO
	PHYSICIAN:		26 HOSPITAL: 1   Inpatient 2   ER/Outpat		OTHER:	ne 5 🗆 Residence	6 🗆 Oth	er (Specify)			
NG PHYSIC fler this cer sath with th		27. MANNER OF DEATH  1 Continue 5 Pending	26e. DATE OF INJURY (Month, Day, Year)	28b. TIM	URY W	JURY AT ORK?	28d. DE	SCRIBE HOW IN	JURY OCCU	RED	
TTENDI TTOR: A after da	тер ву	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, etc. (Specify	At home, ferm, a		YES 2 NO	281. LO	CATION (Street and or Town, State)	d Number or	Rural Rou	rte Number,
AL OR LE DIRI	COMPLETED		AN: To the best of my knowled On the basis of examination of								and manner se stated
TO THE HOSPITAL TO THE FUNERAL De filed within 72 P	BE	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU	MBER				fonth, Day, Year)
ク	10	30. NAME AND ADDRESS OF PERSON WHO DR. AARON GOLDBE						21215	.,,,	# E E	
		MAY 02 1995	32. REGISTHAR'S SIGNAT	Lall							



2. DATE OF DEATH HONTH

3. TIME OF DEATH

10d, INSIDE CITY LIMITS?

White

Intarval Batween

Onset and Death

24b. WERE AUTOPSY FINDINGS COMPLETION OF CAUSE

OF DEATH? 1 - YES 2 NO

USA

1 TYES 2 X NO

FOR STATE REGISTRAR

DECEDENT'S NAME (First Middle Last)

QHOMYA.

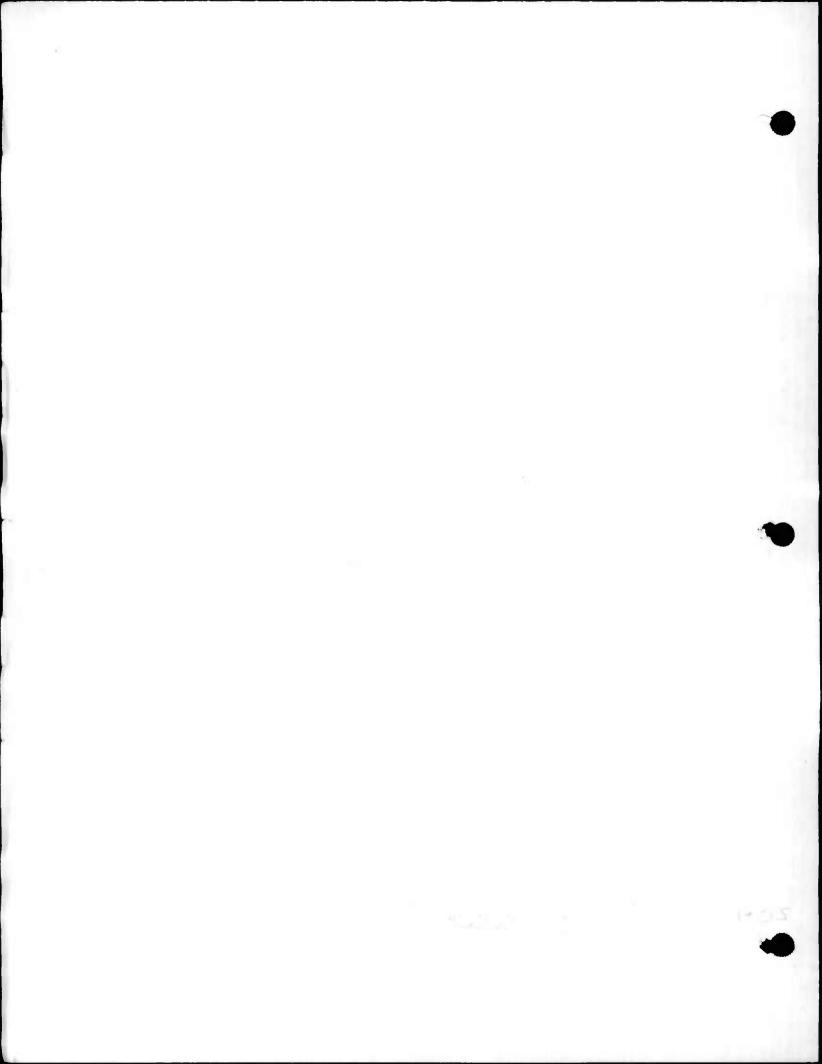
RUBIN

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P.O. BOX 13146	executed with
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OF VITAL	OSPITAL OR ATTENDING PHYSICIAN:
DIVISION	ATTENDING
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	TO THE HOS
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4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH 5. SEX S. BIRT NPLACE (State or Form) IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS 211-16-5876 1 XM 2 F YRS. 926 Dec. Pennsylvania filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN Baltimore Northwest Hospital Center Baltimore DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c, CITY, TOWN OR LOCATION Baltimore Owings Mills Maryland FUNERAL 10e STREET AND NUMBER 10g. CITIZEN OF WNAT COUNTRY? 101. ZIP CODE 21117 4703 Wards Chapel Road after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ∑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify the year, specify Cuban, Maxican, Puerto Rican, atc.) t4. RACE — American Indian. Black, White, atc. 1 Never Married 2 Married 1 TYES 2 TYNO Specify: BY 3 Widowed 4 Divorced WWII 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) E COMPL 12 Post Office Postal Foreman 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Joseph Rubin Ethel Rosenberg notified at BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 4703 Wards Chapel Rd. Owings Mills, MD 21117 Francisco A. Fradejas must be 20s. METNOD OF DISPOSITION

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION - City or Town, State 04/29/95 Metro Crematory, Baltimore, Inc. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Dawn McDonald Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 the medical 23. PART I. Entar the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart fellure. List only one cause on each line this certificate has been signed by the attending physician and completely filled in with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or IMMEDIATE CAUSE (Finel disease or condition resulting in death) item 23 shows any injury, or other traumatic event, CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSPOUENCE OF) If any, leading to immediate etec cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? t YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) EXAMINER? OTHER: 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA TO THE FUNERAL DIRECTOR. After this cerum-be filed within 72 hours after death with the S IMPORTANT: If item 28 is marked, or i e 5 Residence 8 Other (Specify) 27. MANNER OF DEATN 26a, DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY Investigation 2 Accident 28a. PLACE OF INJURY — At home, term, streat, factory, office building, atc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 🔲 Suicide Could not be detarmined COMPLETED 4 Homtcide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(e) and me CHATURE AND TITLE OF CERTIFIER BE 2

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	TMENT OF	HEALTH AND		HYGIENE REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF MONTH	DEATH	YEA	3. 1	TIME OF DEATH
		JERRY W. RICHMO					April		1995		9:51P M
		4. SOCIAL SECURITY NUMBER 533-40-3043	5. SEX 6. AGE	(In yrs. last birthday) 54 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF (Month, E	Day, Year)	C	IRTNPLA	CE (State or Foreign
pinous		9e. FACILITY NAME (If not institution, give st		54 YRS.			Dec.				ngton
3 Sh	Œ	Howard County Ger		al		or Location of D	EATH		9c. COUNTY O		4
1, 2,	DIRECTOR	RESIDENCE OF DECEDENT									
Pages	2	10a. STATE 10b. COUNTY Maryland Ho	oward	10c. CIT	Y, TOWN OR LOCA					10d	I, INSIDE CITY LIMITS?
permit.		10e. STREET AND NUMBER	JWara			lumbia					YES 2 X NO
. usit	FUNERAL	10975 Clarksvil			10	or. ZIP CODE 2104	44		10g. CITIZEN (		S.A.
r use as the bunal-transit		11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 XYES IF YES, GIVE WAR OR D.	2 NO	II yes, s	CENDENT OF NISPAI pecify Cuben, Mexico S 2 X NO Specifi	en, Puerto Ric	Specify Yea or an, atc.)		Black, Wh	Americen Indian, hite, stc.
21215-0020 al or attending physic for use as the bunal	ВУ	3 Widowed 4 Divorced	11 TES, GIVE 1011 ON D	AILS	1 1 1 1 1	S 2 IX NO Specif	ny:		5	Specify:	White
use aft	TED	15. DECEDENT'S EDUC (Specify only highest grade		(Give kind of	USUAL OCCUPATI	ON ost of working			ESS/INDUSTR		
(A = 5	PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	Fxec. V	ice Pre	sident	13	Medical M <b>edic</b> al	Supply	y Co	mpany Company
YLAND 2 by the hospital be detached to at once.	COMPLET	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA				-1	
YL. by the by the d		Stancil Richmond				Cecile	Phill	ips	mame)		
BALTIMORE, MARYLAND ar death. Page 6 may be retained by the hospit the funeral director, page 5 should be detached val. It examiner must be notified at once.	TO BE	Janis W. Richmond	d (Spouse)	19b. MAJLING	ADDRESS (Street	and Number or Rurel Ville Pi	Route Number,	City or Town,	State, Zip Cook	e) and	21044
RE, nay be page		20s. METHOD OF DISPOSITION	206	PLACE AND DATE	OF DISPOSITION (N	lame of	DATE	200 1 004	TION - Clty o	or Town (	Plata
BALTIMORE, after death. Page 6 may be moval. cal examiner must be		1 Surial 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	val from State cen	netery, cremetory or o adownidg	ther place)	May 3	3,1995	Dorse	ey, Ma	ryla	nd
LTI ath. P		21. SIONATURE OF FUNERAL SERVICE LICE	ENSEE			M & RUSS	OIL!!				
BA the fu		Lucience	way y		1630 1	Fdmondsor	a Aven	ue Cat	onsvi		Maryland
hours after ed in by the or removal		23. PART I. Enter the diseases, or conshock, or heart fellure. L	omplications that caused list only one cause on a	f the death. Do r ach ilna.	not entar tha me	ode of dying, suc	th as cardia	c or respirat	tory arrest,		Approximata Interval Between
filled fon, o		IMMEDIATE CAUSE (Final disease or condition								ļ	Onset and Death
760 B within 24 hours after ompletely filled in by th L cremation, or remove event, the medical		resulting in death)	Sudden ca	rdiac de							minutes
cxecuted with and comple burial, cre-	_		Coronary		•					İ	Years -
× ª ººº E	RTIFICATION	Sequantially list conditions, if any, leading to immediate		CONSEQUENCE OF						- i	LEST V.
BOX cate be e ohysician e prior to er traum	CA	Cause, Enter UNDERLYING CAUSE (Disease or Injury									
	E	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	7:						
DS, P. the death c the attend Mental Hy njury, or	E E		•								
- 4 6 5 -	AL	PART II. Other aignificant conditions	1	-	n the UndarlyIn	g cause given in	Part I. 24	In. WAS AN AU			RE AUTOPSY FINDINGS LABLE PRIOR TO
CORD wires that the signed by the Health and I	MEDICAL	31P Coronany A	tery by po	ran x 2			1	YES 2	3/000	COM	MPLETION OF CAUSE DEATH?
- 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			9 1								YES 2X NO
23 Per law	AN	DID TOBACCO USE CONTR					NX				
OTVISION OF VITA OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate h hours after death with the State C tem 28 is marked, or tilem	PHYSICIAN:	EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	OTHER:						
SICIAL Certification the	HYS	27. MANNER OF DEATH	1 Inpatient 2 X ER/Outp 28e. DATE OF INJURY	28b. TIM		JURY AT			URY OCCURED		
NG PHYS fler this ceath with		1 Natural 5 Pending 2 Accident Investigation	Apr 30, 19	INJ	URY WO	YES 2 X NO	10.00		sed su		10
STON TENDING OR: After fter death	D BY	2 Accident Investigation 3 Suicide a Could not be	28s, PLACE OF INJURY building, atc. (Spec	- At homs, farm, a			28f. LOCATIO	ON (Street and	Number or Ru		
OR ATTEN OR ATTEN DIRECTOR: Nours after tem 28 is	ETED	4 Homicide datarmined	Home	жу				n 10e			
L OR A DINE	PLE	29e. CERTIFIER (Check only 1 CERTIFYINO PHYSIC	IAN: To the best of my know	ledge, death occurre	ed at the time, data	and place, and due	to the cause(	e) end manne	r es atated.		
HOSPITAL FUNERAL WITHIN 72 I	COMPL	one) 2 MEDICAL EXAMINER	: On the basis of examination	and/or investigation	n, in my opinion, c	death occured at the	time, data and	d placs, and d	fus 10 the ceu	se(e) and	manner es stated,
THE HOTHER PORTA	W I	296. SIGNATURE AND TITLE OF CERTIFIER		Dena	1	29c. LICENSE NUN	MBER	2	9d, DATE SION	NEO (Mon	ith, Day, Year)
TO THE HOSPIT TO THE FUNERA De filed within 7	TO B	Tanu A	my, mo	MEHE	Indus	DRIA.	13		MAY	11.	9.5
011		30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATN (ITEM 27) (Type,		County (	Genera	1 Host	oital/	Co1u	ımbia MD
011		31. DATE FILEO (Month, Day, Ybar)	32. REGISTRAR'S SIGN			- 7					
10		MAY 02 1386	John Develor	world							
		mmr									DHMH-18 Rev 1/89

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	0.07				

Pantella

5. SEX

1 M 2 M F

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

9a. FACILITY NAME (If not institution, give street and number)

Bel Forest Nursing Home

Elaine

4. SOCIAL SECURITY NUMBER

212-12-9172

296. SIGNATURE AND TITLE OF CERTIFIE

31. DATE FILED (Month, Day, Year) WAY 0.2 1995

0

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

BE

2

1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

IF UNDER 1 YEAR

DAYS

IF UNDER 24 HRS.

29c. LICENSE NUMBER

96. CITY, TOWN OR LOCATION OF DEATH

Bel Air, Maryland

Roberts

6. AGE (In yrs. last birthday)

83

YEAR

9c. COUNTY OF DEATH

Harford County

10g, CITIZEN OF WHAT COUNTRY?

Specify:

U.S.A.

White

2. DATE OF DEATH

April 28,1995

7. DATE OF BIRTH (Month, Day, Year) April 12,1912

BALTIMORE, MARYLAND 21215-0020	TENTS PHYSICIAN: The law requires that the death certificate be executed withhere hours after death. Page 6 may be retained by the hospital or attending physician.	ELEMPA Was certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 second much the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	the ATTENING PHYSICIAN; The law requires that the death certificate be executed within-	PRETURE AND THIS certificate has been signed by the attending physician and completely filled in by the steen that the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

hould

DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION Maryland Forest Hill Harford FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 109 Forest Valley Drive 21014 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Mexican, Puerto Rican, stc.) 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 TES 2 NO Specify: BY 3XXWidowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life, Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 8th Grade Own Home Home Maker 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) be notified at Charles Noyd Selvage BE Rose Unknown 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Nargaret Innis Dauer 1530 Cedarwood Drive, Belair, Maryland -21014 20a. METHOD OF DISPOSITION
145 Burlel 2 Cremation 3 Removal from State must 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State emetery, cremetory or other place)
Baltimore Cemetery 4 Donation 5 Other (Specify) Baltimore, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. albles 6415 Belair Road, Baltimore, Maryland 21206 medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **IMMEDIATE CAUSE (Finel** injury, or other traumatic event, the disease or condition etastalic Unknown Primary resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initieted events resulting in deeth) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? shows any signed Health 1 TYES 2 NO t, of has be Dept. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \( \square\) NO \( \square\) UNCERTAIN \( \sqrta\) PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h **EXAMINER?** HOSPITAL: 1 TYES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA Mursing Home 5 - Residence 6 - Other (Specify) 6 27. MANNER OF DEATH arked 26a, DATE OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Se se 1 Natural 5 Pending 1 YES 2 NO Accident Investigation 3 Sulcide 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 35 8 Could not be 4 Homicide 29a. CERTIFIER CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the besis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 00 TO THE HOS TO THE FLIN De filed with

3. TIME OF DEATH

S. BIRTHPLACE (State or Foreign

Maryland

10d. INSIDE CITY

14. RACE — American Indian, Black, White, atc.

White

Approximate Interval Between

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH?

1 TES 2 NO

28,1995

29d. DATE SIGNED (Month, Day, Year)

Onset, and Death

1 YES 2 NO

11:15A.M

FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

-	1. DECEDENT'S NAME (First		t la la 7	J / 7	7270 1717	_ : _	,		2. DATE	OF DEATH	/A	YEAR 3	TIME OF DEAT
	Else		thschil		KA El				Apri		199		2:10
- 1	4. SOCIAL SECURITY NUM		5. SEX	6. AGE (in yrs. ia		ONTHS D	MYS HOUR	DER 24 HRS.	(Month	OF BIRTH	015	Country)	ACE (State or Fo
-	113 09 26		1 🗆 M 2XXX	79			OWN OR LOC		May	15 1	915		many
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DIRECTOR	Arcola Re		ent & R	enab	l S	Silver Spring Mc					MOI	tgom	егу
Ä [	10a. STATE	106. COUNT	Υ		10c. CITY, T	TOWN OR	LOCATION					1	Od. INSIDE CITY
100	Maryland		tgomery		Sil	Silver Spring							X YES 2 □
FUNERAL	10e. STREET AND NUMBER						10f. ZIP C			10g. CITIZEN OF WHA			
	919 Annmo	re Dr		T 5150 01 11 0 A	U.S. ARMED 13. WAS DECEMBENT OF HISPANI						USA		
	1 Never Married 2	Married		YES 2 🔀	NO	lf y	es, specify C	uban, Maxic	an, Puarto F		or No-	Black, 1	- American Indi White, stc.
M M	3\\X\Widowed 4 □ Div	orced	IF YES, GIYE Y	MR OR DATES	TES 1 ☐ YES 2 💢 NO Specify:							Specify:	Whit
	15. OEC (Specify on	CEDENT'S EOU	CATION completed)	16a. D	ECEDENT'S US	NAL OCCI	UPATION ing most of w	orkina	16b.	KIND OF BU	SINESS/IN	DUSTRY	
COMPLETED	Elementary/Secondary (		College (1-4 or 5	+)	Give kind of wor le. Do NOT use r	14111				D !		D - 1	
	8th		~		lurse'	s A			Щ,			Duty	
	17. FATHER'S NAME (First, A									Alddle, Maiden			
8	Oscar Karl Sophie Florsheim  196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
2	196. IMFORMANT'S NAME (Type/Print) 198. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Eileen Greilsamer Same as item 10 a-f												
	20a, METHOD OF DISPOSIT		20b/PLAC	E AND DATE O				DAT	E 20c. LO	CATION -	City or Town	ı, Stata	
	Westel 2 ☐ Cremeti	y, crematory or	other place	(e)		4/:				, N.J			
ı	21. SIGNATURE OF FUNERAL SERVICE LIGHTER 22. NAME AND AODRESS OF FACILITY										7 21.00		
	Ives-Pearson Funeral Homes Falls Church, Virginia 22046												
	23 PART I. Enter the	Hannan or	1 1/2	<i>Au</i>	leath Do not								4 b
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events												
EH	PERFORMED?  1 UYES 2 NO									VERE AUTOPSY I			
									_			6	WAILABLE PRIOF COMPLETION OF OF DEATH?
MEDICAL												6	WAILABLE PRIOR
MEDICAL	25. WAS CASE REFERRED	TO MEDICAL					26. PLACE O	OF DEATH (C	heck only or	1 TYES		6	WAILABLE PRIOF COMPLETION OF OF DEATH?
MEDICAL		TO MEDICAL	HOSPITAL:	☐ ER/Outpetient		OTHER:				1   YES :		6	WAILABLE PRIOF COMPLETION OF OF DEATH?
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED EXAMINER?  1 YES 2 XNO  27. MANNER OF DEATH	] Pending	1 Inpatient 2			OF 2	g Home 5 [ 8c. tNJURY A WORK?	Residence	6 🗆 Othe	1   YES :	2X NO	1	WAILABLE PRIOF COMPLETION OF OF DEATH?
BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  Whatural 5  2 Accident  3 Suicide 6		1 Inpatient 2  28a. DATE O (Month,)  28e. PLACE	F INJURY	28b. TIME	OF 2 RY M	sc. INJURY A WORK? 1 YES	Residence	6 Othe	1 VES :	NO NO NURY OC	CCURED	WAILABLE PRIOF COMPLETION OF OF DEATH?
PLETED BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  Whatural 5 Accident  3 Suicide 6 4 Homicide  29a. CERTIFIER (Check only)	Pending Investigation Could not be determined	28a. DATE O (Month,  28a. PLACE building	FINJURY Dey, Year)  OF INJURY — At I , etc. (Specify)  I my knowledge, (	3 DOA 4 28b. TIME 6 1NJUS home, farm, str	OF 2 Nursin OF 2 NY M actor	Bc. NJURY A WORK?  1 YES  y, offica	Residence T 2 NO	6 Other 28d, DES 28f, LOC City	1  YES :	INJURY OC	CCURED  or or Rural Ro	WAILABLE PRIOR COMPLETION OF OF DEATHY  YES 2   ute Number,
COMPLETED BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  Whatural 5 Accident  3 Suicide 6 4 Homicide  29a. CERTIFIER (Check only)	Pending Investigation Could not be determined	28a. DATE O (Month,  28a. PLACE bullding	FINJURY Dey, Year)  OF INJURY — At I , etc. (Specify)  I my knowledge, (	3 DOA 4 28b. TIME 6 1NJUS home, farm, str	OF 2 Nursin OF 2 NY M actor	eg Home 5 [ 8c. tNJURY A WORK? 1 [ YES  y, offica  e, data and p	Residence T 2 NO	6 Other 28d, DES 28f, LOC City as to the care time, data	1  YES :	INJURY OC	ccured or or Rural Ro	WAILABLE PRIOR COMPLETION OF OF DEATHY  YES 2   ute Number,
BE COMPLETED BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5  2 Accident  3 Suicide 6  4 Homicide  29a. CERTIFIER (Check only one)  2 MEI	Pending Investigation Could not be determined	28a. DATE O (Month,  28a. PLACE bullding	FINJURY Dey, Year)  OF INJURY — At I , etc. (Specify)  I my knowledge, (	3 DOA 4 28b. TIME 6 1NJUS home, farm, str	OF 2 Nursin OF 2 NY M actor	eg Home 5 [ 8c. tNJURY A WORK? 1 [ YES  y, offica  e, data and p	Residence T 2 NO	6 Other 28d, DES 28f, LOC City as to the care time, data	1  YES :	INJURY OC  and Number  anner as stand due to 1  29d, DA	occured  or or Rural Ro  ated.  the cause(a)	WAILABLE PRIOR COMPLETION OF OF DEATHY THE YES 2   Ute Number, and manner as
O BE COMPLETED BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  1 Natural 5 2 Accident 3 Suicide 6 4 Homicide  29a. CERTIFIER (Check only one) 2 MEI  21b. SIGNATURE AND TITL  30. NAME AND ADDRESS 6	Pending Investigation  Could not be determined  CTIFYING PHYSIDICAL EXAMIN  E OF CERTIFIE  OF PERSON W	28a. DATE O (Month, 28e. PLACE building SICIAN: To the best of ER: On the best of	F INJURY Day, Year)  OF INJURY — At I , atc. (Specify)  I my knowledge, a examination and/or	3 DOA 4 28b. TIME: 8NJU! home, farm, str	OF 2 RY M 2 Rest, factor at the tim in my opi	ng Home 5 Esc. th/Jury A WORK? 1 YES y, offica we, date and pinlon, death of	Residence T 2 NO  No  No  No  No  No  No  No  No  No	6 Other 28d, DEI 28d, DEI 28f, LOC City as to the care time, data	1  YES :	INJURY OC  and Number  anner as stand due to 1  29d. DA	occured  or or Rural Ro  ated.  the cause(a)  TE SIGNED (i	WAILABLE PRIOR COMPLETION OF OF DEATH?  YES 2  Wes Number,  and manner as  Month, Day, Yesr,  28 ,
O BE COMPLETED BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH  12 Accident  3 Suicide 6  4 Homicide  29a. CERTIFIER (Check only one)  2 MEI  2th. SIGNATURE AND TITL	Pending Investigation Could not be determined ATTIFYING PHYS DICAL EXAMIN TO CERTIFIE DETERMINED TO PERSON W	28a. DATE O (Month, 28e. PLACE building SICIAN: To the best of ER: On the best of	F INJURY Day, Year)  OF INJURY — At I , atc. (Specify)  I my knowledge, a examination and/or	3 DOA 4 28b. TIME: 8NJU! home, farm, str	OF 2 RY M 2 Rest, factor at the tim in my opi	ng Home 5 Esc. th/Jury A WORK? 1 YES y, offica we, date and pinlon, death of	Residence T 2 NO  No  No  No  No  No  No  No  No  No	6 Other 28d, DEI 28d, DEI 28f, LOC City as to the care time, data	1  YES :	INJURY OC  and Number  anner as stand due to 1  29d. DA	occured  or or Rural Ro  ated.  the cause(a)  TE SIGNED (i	WAILABLE PRIOR COMPLETION OF OF DEATH?  YES 2  ute Number,  and manner as  Month, Day, Year,

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

(COTTO)

Carrier S

notified at

pe must

arked, or item 23 shows any injury, or other traumatic event, the medical examiner

Im this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal. DIVISION OF VITAL RECORDS, P.O. BOX 68760 OF ATTAINING PHYSICIAN: The law requires that the death certificate be executed within TO THE HOSPITAL OF WITH TO THE FUNERAL DIRECTE BE filed within 72 house IMPORTANT: It item 21

BE COMPLET

9

4 Homicide

									95	;	3265	
	1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND C	DEPAR	RTMENT OF	HEALTH AND	MENT	AL HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last, DORA ELIZA		CINCHCOM				MON	RIL 28,	1999	YEAR 5	3. TIME OF GEAT	гн Р м
	4. SOCIAL SECURITY NUMBER 215-05-7238	5. SEX	6. AGE (In yrs. le	yast birthday)	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7 DAY	V 11 1005 Cou		8. BIRTHI Country	RTHPLACE (State or Foreign unity) RYLAND	
LOR	9a. FACILITY NAME (If not institution, give 603 STEWART AVE				96. CITY, TOWN	OR LOCATION OF D			9c. COU	NTY OF DE		
DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  MARYLAND  BAL	TIMORE			Y, TOWN OR LOC ALTIMORI				10d. INSIDE CITY LIMITS? 1 YES 2 X			
FUNERAL	106. STREET AND NUMBER 2808 OHIO AVE.				1	01. ZIP COOE 21227			-	IZEN OF W	HAT COUNTRY?	
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 🔀 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	IT EVER IN U.S. AI YES 2 X WAR OR DATES	RMED NO	If yes, s	CENDENT OF HISPA pecify Cuban, Maxic S 2 (X) NO Spec	an, Puerte	ilN? (Specify Yes o Rican, etc.)	or No—	Black	- American Indi White, etc.	BO,
COMPLETED	15. OECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) 8 YEARS	College (1-4 or 5 NONE		ECEDENT'S Give kind of the Do NOT us FORE	- '	TION nost of working	10	CLOTHI		DUSTRY		
BE CO	17. FATHER'S NAME (First, Middle, Last)  ELMER		IGLETON JANE (First, Mich						WOOD			
10	190. INFORMANT'S NAME (Type/Print) MYRTLE G. PUPPE		19	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8008 HARFORD ROAD, BALTIMORE, MARYLAND 21234								
	20e, METHOD OF OISPOSITION 1 N Buriel 2 Cremetion 3 Rer 4 Donation 5 Other (Specify)		cemetery, cre	emetory or o	CEMETERY	7	57 19	1 20c. LON 95 WOOD	LAWN	, MAI	rn, Stata RYLAND	
	· The	FI			SING 1 SEC	LETON FUN COND AVE	VERAI S.V	HOME	N BUE	RNIE,		61
	23. PART I. Enter the disease, or chock, or heart feliure.  IMMEDIATE CAUSE. Final disease or condition resulting in death)	e. U) OCL DUE TO	ise on eech line	0.							Approximinterval Bronset and	etween
RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted events resulting in death) LAST	c	(OR AS A CONSE									
PHYSICIAN: MEDICAL CEI	PART II. Other algnificant condition	ana contributing to	deeth but not i	reaulting (	in the underlyl	ng cause given in	Part i.	24a. WAS AN PERFOR	MED?		WERE AUTOPSY FI AMAILABLE PRIOR COMPLETION OF CO	TO
AN: N	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CA			S NO E		Ν□				1 - YES 2/0	10
YSICI	EXAMINER?  1 YES 2 NO	HOSPITAL:	ER/Outpetient 3		OTHER:	me 5 Residence	8 Oth	er (Specify)				
27. MANNER OF DEATH 286. DATE OF INJURY (Month, Dey, Year) 286. TIME OF 28c. INJURY AT WORK? 286. DESCRIBE HOW INJURY OCCURED												

27. MANNER OF DEATH 10 Natural 1 YES 2 NO 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29s. CERTIFIER (Check only one)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

ne, date and place, and due to the cause(s) and menner se stated.

296. SIGNATURE AND TITLE OF CERTIFYER 29c. LICENSE NUMBER 29d. DATE SIGNED (Mgnth, Day, Year) 10

ARMORY BUILDING DR. FRANK R. CLAUDY MARYLAND 21201

who completed cause of Dearth (ITEM 2) (1999, Print)
MARYLAND GENERAL HOSPITAL,
AUDY 827 LINDEN BALTIMO

32. GEGISTAR'S SIGNATURE

Jalian Division Family 1898

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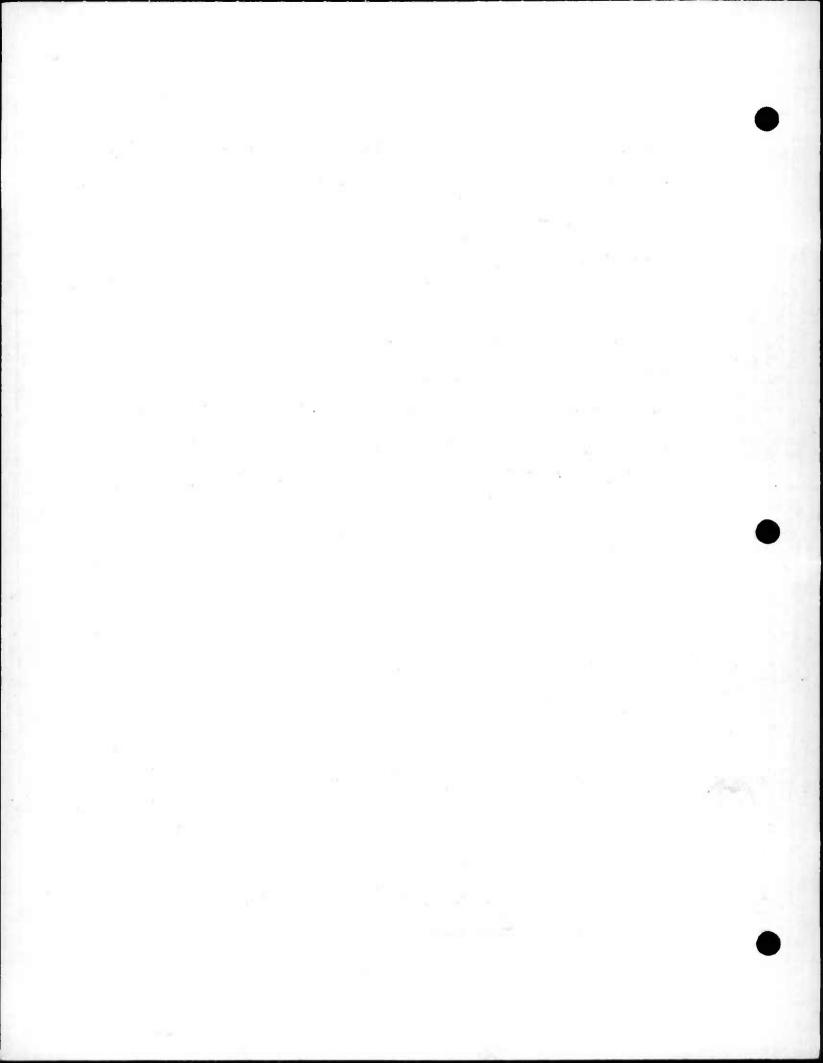
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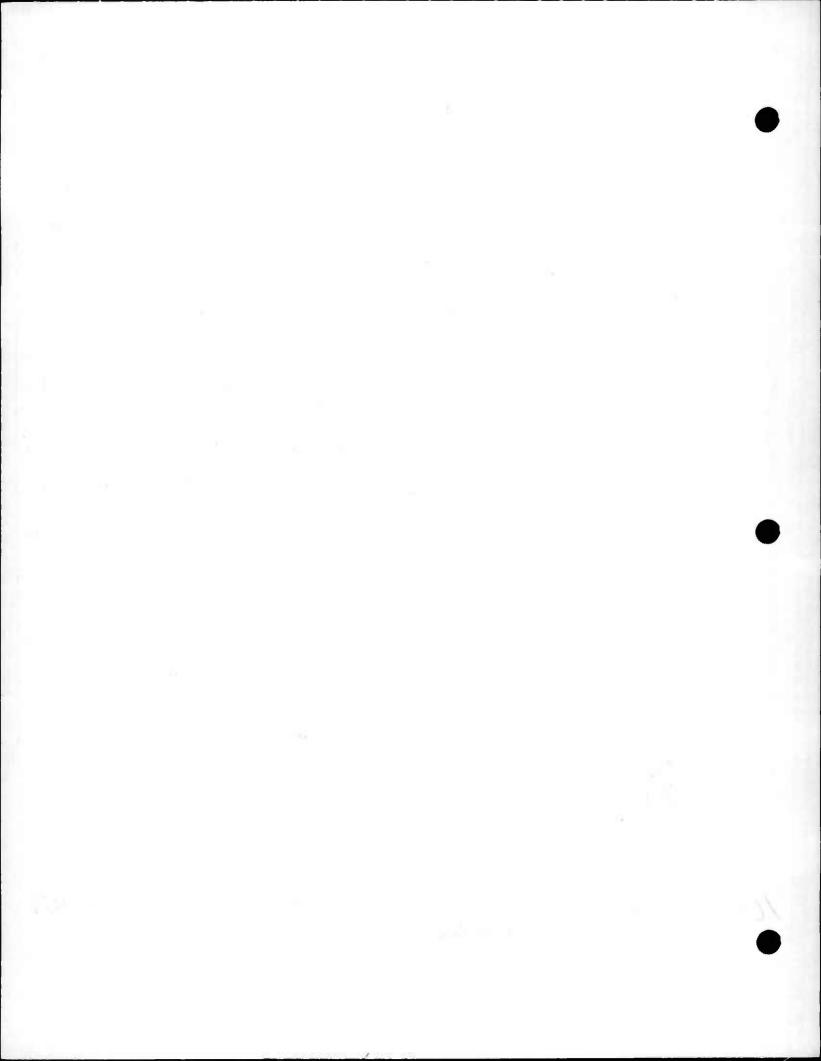
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J BALTIMÓRE, 31. DATE FILED (Month, Day, Year) MAY 0 2 1995



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		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTME	ENT OF HEALTH AN	ID MENTA	L HYGIENE REG. NO.		
		1. DECEOENT'S NAME (First, Middle, Last)		11	- 1 1	2. DATE MONT	OF OEATH		TIME OF DEATH
	1	Louis Her	Menegi	190	Algado	Apri	1 30 19	YEAR 195	8:00 A
99		218-18-6073	5. SEX 6. AGE (In	yrs. last birthday) IF U	HOER 1 YEAR JF UNDER 24 H	/A 4n	OF BIRTH h, Day, Year)	PORT	ACE (State or Foreign
2, 3 should	OR	South 52 md.	Street 2	+31	CALOATE	OF OEAT/1	9c. COU	NTY OF DEAT	
	12	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY	1	10c CITY TOY	N OR LOCATION		10/1	140	
permit. Pages	L DIRECTOR	MARYLAND BA  100. STREET AND NUMBER	HIMORE	Col	gate			1	d. INSIDE CITY LIMITS?  YES 2 PNO
TST.	FUNERAL	South 52'm	d. Street	431	101. ZIP CODE	24	(	L S	A A
020 physic burial	1	1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1  YES	2 NO	13. WAS DECENDENT OF HI If yes, specify Cuben, M	axican, Puarto	I7 (Specify Yes or No— Rican, etc.)	Black, W	American Indien, /hite, etc.
215-0020 attending physician se as the bunal-tra	BY	3 Wildowed 4 Divorced	WWJI	25	1 FYES 2 NO S	Pont	uguese	Specify:	white
	TED	15. DECEDENT'S EDUI (Specify only highest grade	CATION completed)	16a. DECEDENT'S USUA (Give kind of work di	one during most of working	166	KIND OF BUSINESS/INC	USTRY	
AND 21 the hospital or detached for u	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT use retin	er.		BAKE	RY	
		17. FATHER'S NAME (First, Middle, Last)	1	C = I	16. MOTHER	S NAME (First,	Middle, Malden Surname)	7	,
RYL ned by		19a. INFORMANT'S NAME (Type/Print)	ugusto	SAIGAdo	We	NA	Julced	2 7	042A
MAR retained 5 should notified		The odore Ti	IPR	E A et 1	ESS (Street and Number or R	TURN Route Num プレフロ	ber, City or Town, State, Zip	Code)	212 30
ALTIMORE, beath. Page 6 may be funeral director, page		20a. METHOD OF DISPOSITION	20b.1	PLACEAND DATE OF DIS	POSITION (Name of	DAT	E 20g LOCATION -	City or Town.	State
AOR pe 6 ma rector, p		1 Burial 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	oval from State came	tery, crematory or other pla	WN MA	W 2.19	93 Easta	rent.	Marylan
ALTIN death. Pag tuneral di l.	ĵ	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	0	22. NAME AND ADDRESS O	FFACILITY	Characas	KAF	Uba
- 0 - 0		Mark	a. (he	in l	1005 Dun	dall	AUR Pal	to it	1/2/2/20
aft aft		23. PART I. Enter the disesses, or o	complications that caused List only one cause on ea	the death. Do not er	iter the mode of dying,	such as care	flec or respiratory srr	rest,	Approximate
D D O E		IMMEDIATE CAUSE (Final	/						Interval Between Onset and Deat
mather than		disease or condition resulting in desth)	a	CANCE	3				SIX MONTE
N 8 8 - 6			DUE TO (OR AS A	CONSEQUENCE OF):					
	ERTIFICATION	Sequentielly list conditions, if any, lesding to immediate	DUE TO (OR AS A (	CONSEQUENCE OF):					
Tie be	SAT	cause. Enter UNDERLYING CAUSE (Disease or Injury	G						
P.O. B th certificat ending phy II Hygiene p	E	that initiated eventa resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):					
O F BE P	CER	resulting in destn) CAS1	đ						
RDS, at the dea by the att and Menta v Injury.	CAL	PART II. Other significant condition		1 not resulting in the	underlying cause give	n In Pert I.	24s. WAS AN AUTOPSY		RE AUTOPSY FINDINGS
<b>■</b> # • # <b>■</b>	1 0	DEHYDRATIO	N				PERFORMED?	co	MILABLE PRIOR TO MPLETION OF CAUSE DEATH?
L RECOl law requires that as been signed bept, of Health and 23 shows and	MEDIC								YES 2 NO
- se se N		DID TOBACCO USE CONTI				AIN 🖳			
OF VITAL PHYSICIAN: The law this certificate has with the State Dep	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 IN NO	HOSPITAL:		IER:				
2 54 0	≥	27. MANNER OF DEATH	1 ☐ Inpetient 2 ☐ ER/Outpet	lant 3 DOA 4 D	Nursing Home 5 Realde		(Specify)	CHRED	
	<u>ه</u>	Naturel 6 Pending Investigation	(Month, Day, Year)	INJURY	WORK?		CRIBE HOW INJURY OCC	JUNED	
ATTENDING I ECTOR: After s after death	D BY	B Could not be	28a. PLACE OF INJURY - butiding, atc. (Specifi	At home, farm, street,		28f. LOC	ATION (Street and Number	or Rural Route	Number,
		Hosizide determined	buttung, atc. (Specif	"		City	or Town, State)		
	COMPLETED		CIAN: To the best of my knowle						
HOSPITAL FUNERAL WITHIN 72	8		R: On the basis of examination	and/or investigation, in r	ny opinion, death occured a	t the time, data	and place, end due to th	a ceuse(a) an	d manner as stated.
물 물 물 등	H	296, SIGNATURE AND TITLE OF CERTIFIER	da hot	\	29c. LICENSE			E SIGNED (Mo	
223	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF OFFI	H (ITEM 27) (Tono Date)	1096	304	►\v[c	1 YS	773
11		Capal Rich	Rdson M	^	Fankly	C 1	Rossvil	1 11	101120
10		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT		ITCAMI IIN	-g. U	K MOSSA:	10 M	1 4 143 /
	1 1	MAY u 2 1995 4	14 Dander Par	1.11				-	



DIVISION OF VITAL RECORDS, P.O. BOX 68760

After

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	Pages	,	
death certificate be executed within ear hours after death. Page 6 may be retained by the hospital or attending physician.	if the this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1,		
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HYSICIAN: The law req	certif	eath with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH 1995^{YEAR} April 25, ELENA SARAKAUSKIENE 20 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year Feb. 1, IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign MONTHS DAY HOURS n/a 1 M 2/3/X Lithuania 70 1925 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 9628 Rocksparkle Row Columbia Howard County RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Howard County Columbia 1 YES 2 PONO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 9628 Rocksparkle Row 21045 Lithuania 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 22000 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE - American Indian, Black, White, stc. 1 Never Married 2 Warried If yes, specify Cuban, Maxican, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES 1 TES 2 XX Specify: BY Specify: 3 Widowed 4 Divorced white COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) unknown Dentist Dental Practice 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Jonas Samsanavicius Ona Samsanaviciene-Kmieliauskhite BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. Al Grintalis 9628 Rocksparkle Row, Columbia, Maryland 21045 20a METHOD OF DISPOSITION
1 Department 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Baltinore Masnington Crematory 4/27/95 5 Other (Specify) Laurel, Maryland OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Slack Funeral Home, P.A. lella M00535 Ellicott City, Maryland 21043 23. PART I. Enter the diseases, or complications that eaused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Finei Onest end Dsath disease or condition _____ resulting in death) butastatic par creatic DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF). if any, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted eventa resulting in deeth) LAST PART ii. Other eignificant conditione contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 2 NONO 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL 1 YES 2 NO ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 4 Nursing Home Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Ybar) 26c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Suicide 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 28 29s. CERTIFIER
(Check only one)

29 MEDICAL EXAMINED: On the best of my knowledge, death occurred at the time, data and place, and dus to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOPPING TO THE FILE BE filed w 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month Day, Year) BE CRILLIS M.D 241139 4/26

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Devoler Radall

32. REGISTRAR'S SIGNATURE

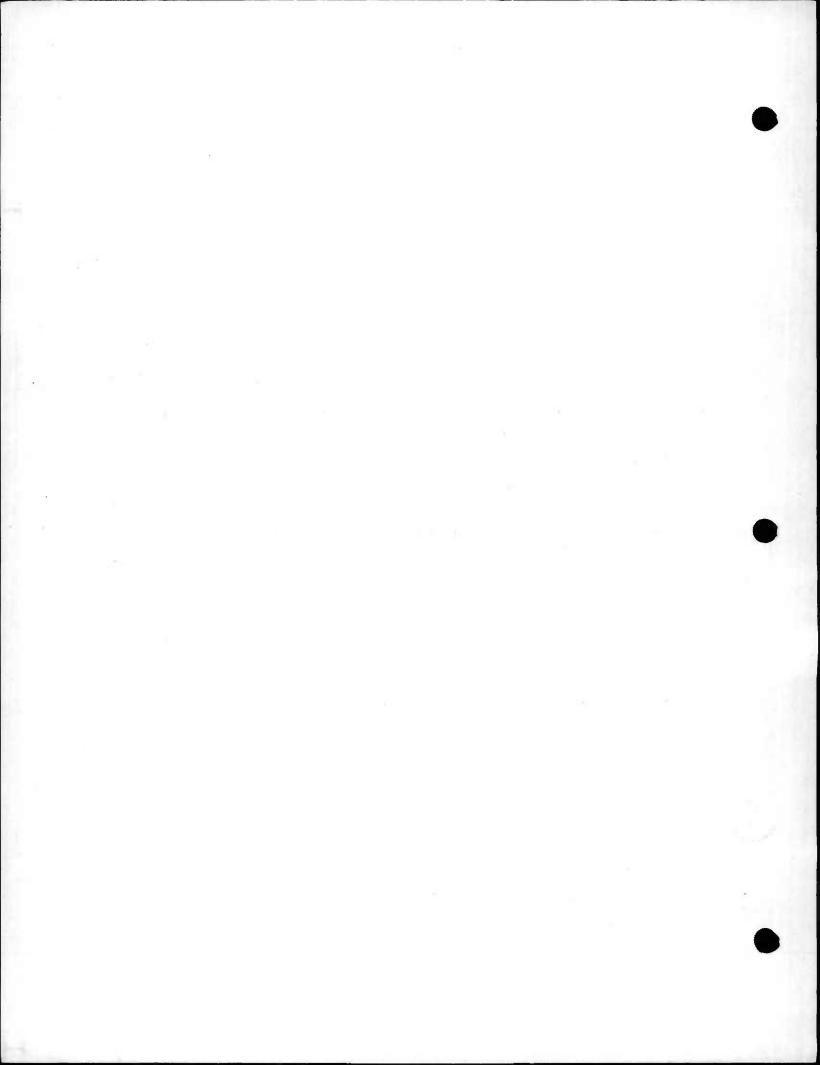
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31. DATE FILED (Month, Day, Year) MAY 0 2 1995

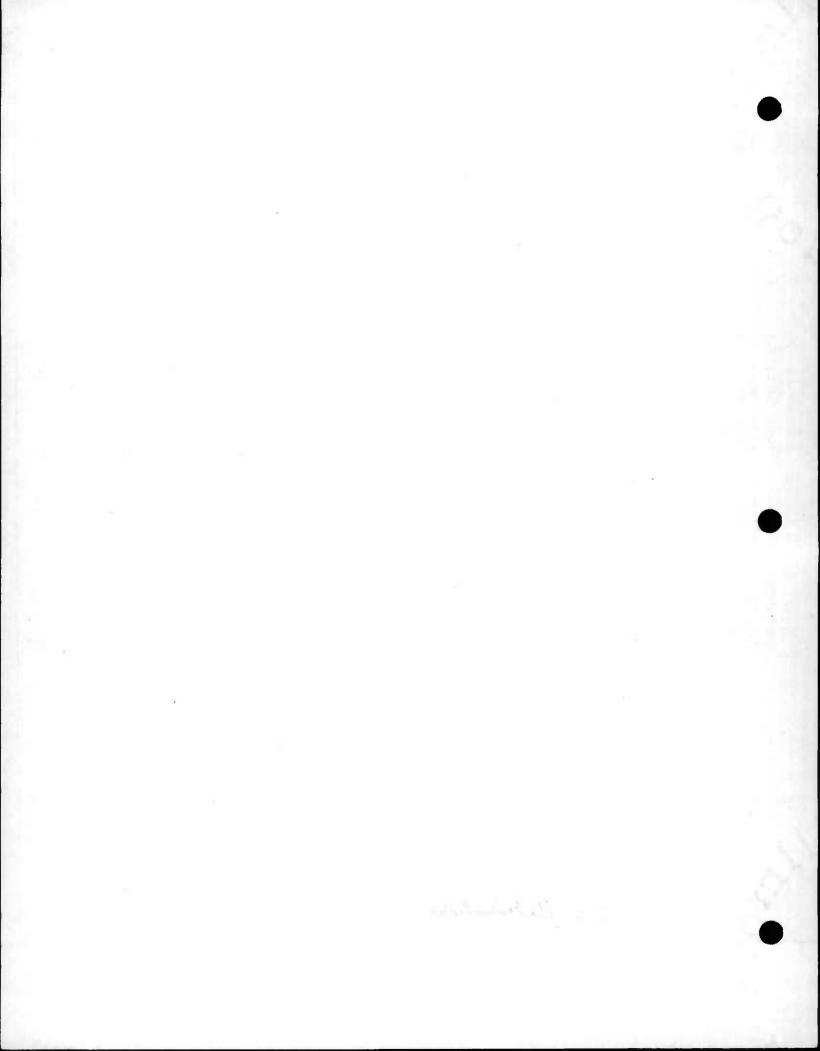
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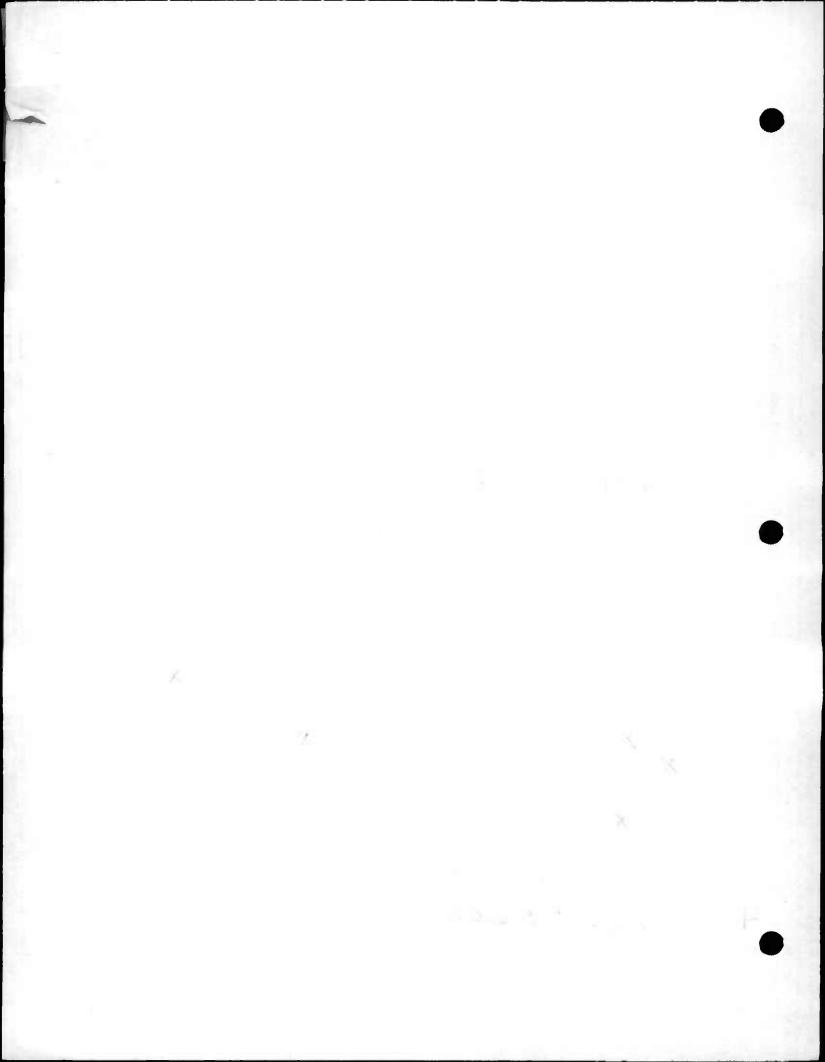
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	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC			TAL HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)	JAMES	R:	SUT	TON 2.0	ATE OF DEATH DAY	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER 230-12-5146	iX□KM 2 □ F		UNDER 1 YEAR WITHS DAYS	IF UNDER 24 HRS. 7. D HOURS MIN.		BIRTHPLACE (State or Foreign Country) VA			
TOR	90. FACILITY NAME (If not institution, give s  THE UNION  RESIDENCE OF DECEDENT	MEMORIAL			OR LOCATION OF DEATH		y of DEATH			
- DIRECTOR	MD 10b. COUNT	n/a	toc. CITY, To		ltimore		10d. INSIDE CITY LIMITS?  ∑≦ X YES 2 □ NO			
FUNERAL	2413 Hermosa				21214		USA			
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1-1-YES IF YES, GIVE WAR OR DA	2 NO	If yes, sp	CENOENT OF HISPANIC OF hecity Cuben, Maxican, Pus 3 2 NO Specify:	IIGIN? (Specify Yea or No.— 1- rto Rican, etc.)	RACE — American Indian, Black, White, etc. Specify: Black			
COMPLETED	t5. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USU (Give kind of work life. Do NOT use re Cler)	done during mo lired.)	ON ost of working	166. KIND OF BUSINESS/INDUS				
ш	4yrs. + Clerk  77. FATHER'S NAME (First, Middle, Last)  Robert Sutton				Post Office  18. MOTHER'S NAME (First, Middle, Meiden Surname)  Carrie Day					
TO B	19a. INFORMANT'S NAME (Type/Print) Gladys Sutto:	Number, City or Town, State, Zip Co								
	206. PLACE AND DATE OF DISPOSITION   DATE   206. LOCATION - City or Town, State   Commetted   2   Cremation   3   Removal from State   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Commetted   Com									
CERTIFICATION	disease or condition resulting in death)  a									
MEDICAL CI	PART II. Other significent condition	a contributing to deeth bu				24s. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDIN AVAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH?			
	DID TOBACCO USE CONTI		F DEATH YES		UNCERTAIN [		1 - YES 2 1-NO			
PHYSICIAN:	EXAMINER?  1 YES 2 NO  27. MANNER OF DEATH	HOSPITAL: 1 Minpetient 2 ER/Output 28e. DATE OF INJURY	01	HER: Nursing Hom	ne 5 Residence 8 C					
D BY P	1 Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year) 28e. PLACE OF INJURY	— At home, term, stree	M 1 1	PRK? YES 2 NO 28t, 1	DESCRIBE HOW INJURY OCCUI				
COMPLETE	4 Homleide determined  29e. CERTIFIER (Check only 1 CERTIFYING PHYSI		edge, death occurred at		and place, and due to the	City or Town, State)  ceuse(a) and menner as stated.				
TO BE CO	29b. SIGNATURE AND TITLE OF CERTIFIES  30. NAME AND ADDRESS OF PERSON WH	ich r	1.0.		29c. LICENSE NUMBER ATZ438	946-76 > A	Poril 30, 9			
	DINA DARWIS		Univers		PKWV 9	Baltimore	MD 212/8			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within exhours after death. Page 6 may be retained by the hospital or attending physic	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - STATE REGISTRAR	STATE OF MA					DEAT		MENT	AL HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, RC	bert Wayne :	Starkev	. T.						2. DATE OF OEATH MONTH DAY YEAR April 26, 1995 4:25 p				
	4. SOCIAL SECURITY NUMBER 214-16-4445		AGE (In yrs. lest		IF UNDER	1 YEAR	IF UNDER	24 HRS, MIN.	7. DAT (Moi	E OF BIRTH nth, Day, Year)		8. BIRTH	PLACE (State or Foreign	
<b>E</b>	9a. FACILITY NAME (If not institution, 145 N. Patter				9b. CITY		R LOCATION		Fet ATH	12,	9c. COUN	TY OF D	ington, DC	
CTC	RESIDENCE OF DECEDEN  10a. STATE 10b. CO	LITAE		<u> </u>			-e			N/.	A			
DIRECTOR	Maryland	N/A		Baltimore							10d, INSIDE CITY LIMITS? 1 TY YES 2 NO			
FUNERAL	100. STREET AND NUMBER 145 N. Patters	on Park Aver	nue			101	. ZIP CODE	2123	1		10g. CITIZEN OF WHAT COUNTRY? USA			
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	EVER IN U.S. ABI YES 2 XN R OR DATES	IN U.S. ABMED  13. WAS DECENDENT OF HISPANIC  15. WAS DECENDENT OF HISPANIC  16. Yea, specify Cuban, Maxican,					IIC ORIG	IN? (Specify Yea o Ricen, etc.)	— American Indian, , Whita, atc.				
COMPLETED	15. OECEDENT'S (Specify only highest Elementary/Secondary (0-12)	S EDUCATION grade completed)  College (1-4 or 5+)	16e. DEC (Gh ilfe.	CEDENT'S re kind of a Do NOT us	USUAL Of work done se retired.)	CCUPATIO	ON sl of workin	9	16	b. KIND OF BUS	INESS/INDU		hite	
P P	12 17. FATHER'S NAME (First, Middle, Las	er)	Cos	smet	ologi	İst	40.1400			Beauty		n		
BE C		layne Starkey	. Sr.					'Unki		Middle, Maiden S				
2	19a. INFORMANT'S NAME (Type/Print)		19b				nd Number	or Rural F	loute Nur	nber, City or Town	, State, Zip C			
	David Bentzel 200. METHOD OF DISPOSITION		20b. PLACE A					Park		. Balt			D 21231	
	1 Donation 5 Other (Specify)		Metro	Cret	ther place) Nator	V.	Inc.	04,	/27/	95 Ba]	timo	re.	m, State	
	21. SIGNATURE OF FUNERAL SERVI	me Donald	F. McDor	nald	22.	rema	ation	s of fac	ociety of Maryland, Inc.					
ERTIFICATION	immediate cause (Final disease or condition resulting in deeth)  Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST	ON BOCK IIING.  STAR  R AS A CONSECUTOR  R AS A CONSECUTOR  R AS A CONSECUTOR  R AS A CONSECUTOR  R AS A CONSECUTOR	CONIA  JUENCE OF):  MAYIVM COMPLY  JUENCE OF):  JUENCE OF):						et,	Approximate interval Batween Oneat and Deeth				
MEDICAL CE	PART II. Other significant cond	eath but not re	eeulting in the underlying ceuse given in P					Part I. 24s. WAS AN AUTOPSY PERFORMED?				WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?  1 YES 2 NO		
N	DID TOBACCO USE CO					-	UNC	ERTAIN	10				1 123 2 NO	
HYSICIAN: MED	25. WAS CASE REFERRED TO MEDIC. EXAMINER?  1 YES 2 NO	HOSPITAL:	26. PLACE		OTHER	l:	~		-					
H H	27. MANNER OF DEATH	28a. DATE OF IN (Month, Day,	JURY	26b. TIM		28c. INJL WOI	RY AT	ildenca 1	-	er (Specify) SCRIBE HOW IN	JURY OCCU	RED		
20	1 Natural 5 Pending 2 Accident Investigat	tion			М	1 🗌 Y	ES 2 🗌	NO						
EIED	_ o _ could no	3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 28t. LOCATION (Street and Number or Rural Rou City or Town, State)										ute Number,		
29a. CERTIFIER (Check only one)  29a. CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.  29a. MEDICAL EXAMINER: On the beat of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.									end manner ea stated.					
#	29b. SIGNATURE AND TITLE OF CERT	v Jude. N	I.D.				29c. LICEI	NSE NUM	BER 44				Month, Day, Year) 27, 1995	
2	30. NAME AND ADDRESS OF PERSON Colleen Jude, 1					alti	more	MI	21	201	71/1	.J.L 4	-1, 1999	
	MAY 02 1995	Windson W	LANGUA PRE	<u> </u>	• 10	<u> </u>	MOLE	, FIL	41.	<u> </u>				



3. TIME OF OEATH

1995 01:00 AM M

10d. INSIDE CITY

14. RACE — American Indian, Black, Whits, stc. Specify: White

1 X YES 2 NO

8. BIRTNPLACE (State or Foreign Country)

2. DATE OF DEATH

27th

7. DATE OF BIRTN OCt. 16, 1919 Maryland

9c. COUNTY OF GEATH

USA

A.A. COUNTY

10g. CITIZEN OF WHAT COUNTRY?

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FOR STATE REGISTRAR

ROBERT

DIRECTOR

permit.

10a. STATE

MD

10e. STREET AND NUMBER

31. DATE FILEO (Month, Day, Year) MAY 0 2 1995

4. SOCIAL SECURITY NUMBER

216-18-5737

1. DECEDENT'S NAME (First, Middle, Last)

9s. FACILITY NAME (If not institution, give street and number)

1110 Court Revere

B

1 M 2 F

Anne Arundel

5. SEX

NORTH ARUNDEL HOSPITAL ASSOCIATION RESIDENCE OF DECEDENT

19h. COUNTY

AND 21215-0020  he hospital or attending physic detached for use as the burial	BY FU	1 Never Married 2 Married 3 Widowed 4 Diverced	FORCES? 1 YES	2 NO	If yes, sp	CENDENT OF NISPAN secify Cuban, Maxica 5 2 NO Specify	IIC ORIGIN? (Specify Yein, Puerto Ricen, stc.)	3 or No—	14. RACE — Americ Black, White, etc Specify: Whi	C.			
21215-00 al or attending p for use as the t	ETED	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12)	UCATION de completed) College (1-4 or 5+)	16a. DECEDENT'S US (Give kind of worl life. Do NOT use n	UAL OCCUPATION done during months	ON ost of working	16b. KIND OF BU	16b. KIND OF BUSINESS/INOUSTRY					
AND 2 the hospital detached to	COMPL	7 Fire Fighter					Anne	Arun	ndel Co	unty			
FORE, MARYL e 6 may be retained by t ector, page 5 should be must be notifiled at	101	u   Glover C. Sears   Eugle Jones											
		19a INFORMANT'S NAME (Resolving)											
		20a. METHOD OF DISPOSITION 1. Burlat 2 Cremation 3 Rai 4 Donation 5 Other (Specify)	moval from State Cen	netery, cremetory or other	place)	hurch C			tty or Town, Stata	le MD			
SALT death. e funera		21. SIGNATURE OF FUNERAL SERVICE L	N Harde i	tu	Hard	esty Fu	neral Ho	me, I	P.A.				
hours aft ad in by or remo		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cerdiec or respiratory arrest, ahock, or heart fellure. List pnly one cause pn each line.  IMMEDIATE CAUSE (Finel											
within pletely cremati		disease or condition resulting in death)											
ECCKDS, P.O. BOX 68; puries that the death certificate be execute a signed by the attending physician and or Health and Mental Hygiene prior to buria every any injury, or other traumatic		Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):											
	MEDICAL C	PART II. Other significant condition	is fibrillah	ali-			PERFOR 1 YES 2	RMED?	24b. WERE AUTO AWARABLE COMPLETIC OF DEATH? 1 \( \text{ YES}	PRIOR TO ON OF CAUSE			
as b	SICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CAUSE O	26. PLACE OF DEATH		UNCERTAIN							
VII A NITAN: The ruificate h he State I	YSIC	EXAMINER?	HOSPITAL:	_ 0	THER:	e 5 🗆 Residence	B Other (Specify)						
TO THE MOSPITAL ON ATTENDING PHYSICIAN: The TO THE CURE WHEN CHE TO THE CHIEF TO THE CHEEF WITH THE STATE IMPORTANT THE TABLE IS MARKED, OF HEM.	ву рну	27. MANNER OF OEATN  1 Netural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME O	WO	URY AT RK? YES 2 NO	28d. DESCRIBE NOW II	NJURY OCCU	RED				
		3 Suictde 8 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, etc. (Spec	' — At home, farm, stree city)	et, factory, office		28f. LOCATION (Street a City or Town, State)	nd Number or	r Rural Route Numbe	r			
	COMPLETED	2 MEDICAL EXAMIN	SICIAN: To the best of my know ER: On the basis of examination	ledgs, death occurred s n and/or investigation, is	t the time, data n my opinion, d	and place, and due	to the csuse(s) and men	ner as stated	i. cause(s) and manne	or as stated.			
	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER  29c. LICENSE NUMBER  29d. DATE S											
10		30. NAME AND ADDRESS OF PERSON W		1600 Cra	ain Hi	ghway S	.W Glen	Burn	ie, MD	21061			
		31. DATE FILEO (Month, Day, Year)	W DRUGISTIANS CON	Fall									

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

SEARS

10c. CITY, TOWN OR LOCATION

Odenton

8. AGE (In yrs. lest birthday)

75

Sr.

IF UNDER 1 YEAR IF UNDER 24 HRS.

GLEN BURNIE

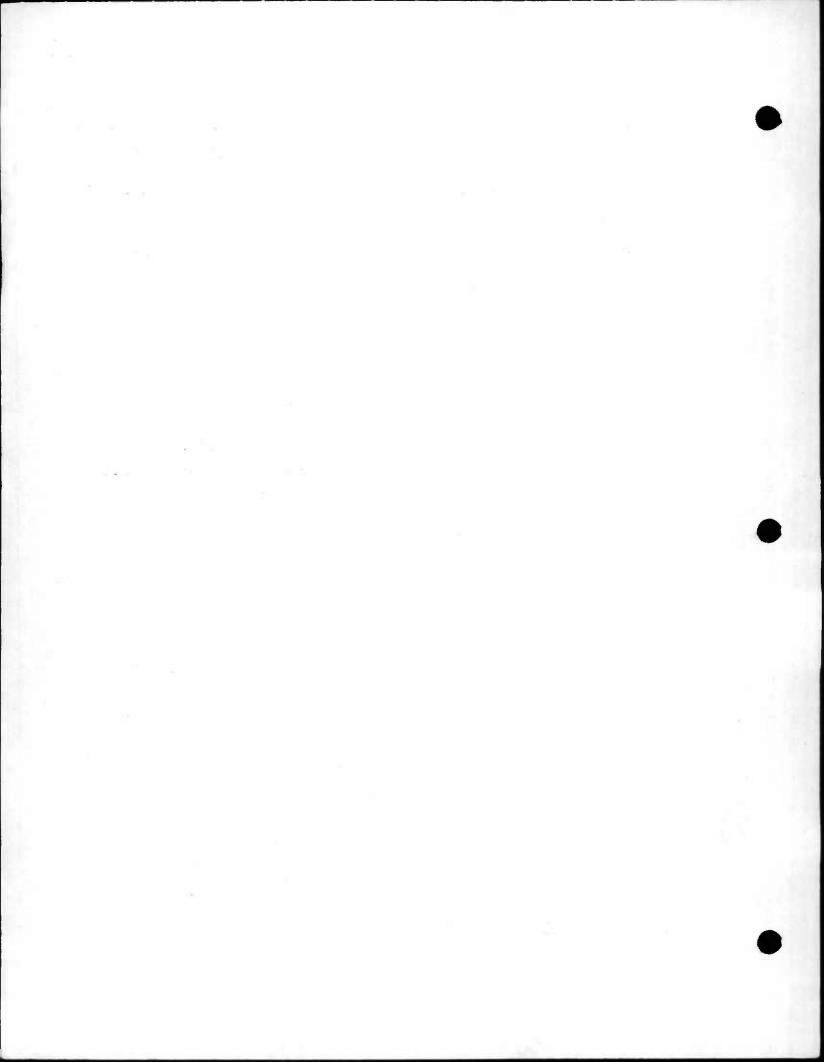
9b. CITY, TOWN OR LOCATION OF DEATN

10f. ZIP CODE

21113

DAYS

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	PHYSICIAN:
	ATTENDING
	OR
	SPITAL

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 flours after death. Page 6 may be retained by the hospital or attending physician.  TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.  MPORTANT: If Item 28 is marked, or litem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
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Item # 1 Film # G 723	5-2-95 N.A. Pe	r Funeral H	ome		95	32/1			
1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART	IMENT OF HEALTH AND CATE OF DEATH	MENTAL HYGIENE REG. NO.					
1. DECEDENT'S NAME (First, Middle, Las	"TIMMONS	Mary Edwi		2. DATE OF DEATH MONTH DAY APRIL 39	YEAR	ME OF DEATH			
4. SOCIAL SECURITY NÓMBER 249-01-3245	1 □ M 2XXF	(In yrs. last birthday) 93 YRS.	IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 10-07-1901	8. BIRTHPLAC	E (State or Foreign CAROLINA			
98. FACILITY NAME (If not institution, ph. FOREST HAVEN NUR			96. CITY, TOWN OR LOCATION OF CATONSVILL		SC. COUNTY OF DEATH BALTIMOR				
RESIDENCE OF DECEDENT  10a. STATE  10b. COUI  MARYLAND	BALTIMORE		INSIDE CITY LIMITS?						
100. STREET AND NUMBER 2817 MICHIGAN AVENUE 101. ZIP CODE 102. CITIZEN OF WHAT COUN 21227 U.S.A.									
FOREST HAVEN NURSING HOME  RESIDENCE OF DECEDENT  10e. STATE  10e. COUNTY  MARYLAND  BALTIMORE  10e. CITY, TOWN OR LOCATION  BALTIMORE  10f. ZIP CODE  2817 MICHIGAN AVENUE  10g. CITIZEN OF WHAT COUNTRY?  21227  11. MARITAL STATUS  XX Never Merried  12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES  13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify: WHITE									
15. DECEDENT'S EI (Specify only highest gra Elementary/Secondary (0-12) UNKNOWN	College (1-4 or 5+)	(Give kind of wo	USUAL OCCUPATION ork done during most of working or refired.)	16b. KIND OF BUSINE	SS/INDUSTRY				
15. DECEDENT'S EI (Specify only highest gra Elementary/Secondary (0-12) UNKNOWN  17. FATHER'S NAME (First, Middle, Last) EDWARD M. TI	MMONS			IAME (First, Middle, Maiden Surn					
EDWARD M. T.1  190. INFORMANT'S NAME (Type/Print)  LINDA DONESKI	11010		ADDRESS (Street and Number or Run 218 STREET, PAS	Il Route Number, City or Town, St					
20a. METHOD OF DISPOSITION 2 Burlel 2 Cremetion 3 Re 4 Donetion 5 Other (Specify)	moval from State	PLACEANDDATEO	FDISPOSITION (Name of	_ DAJE, 20c. LOCATI	ION — City or Town, Si				
21. SIGNATURE OF FUNERAL SERVICE			22. NAME AND ADDRESS OF I 1 SECOND AVEN GLEN BURNIE	FACILITY SINGLETON UE, S.W.	N FUNERAL				
23. PART I. Entar the diseases, o shock, or heart fallur IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Acute	ach line.	ot enter the mode of dying, su	ch as cardlec or respirato	ory arrest,	Approximate Interval Batween Onset and Death			
Sequentielly list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	¢	CONSEQUENCE OF)							
PART II. Otherwignificant condition  H2HE1  - H4 P0 TH	ons contributing to death b MERS I POIDISM	ut not resulting in	the underlying cause given i	Pert I. 24e. WAS AN AUTPERFORMED	O? AWAIL COMP	AUTOPSY FINDINGS ABLE PRIOR TO LETION OF CAUSE ATH? YES 2 3 NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO	HOSPITAL:		PLACE OF DEATH (COTHER:						
24b. WERE AUTOPSY FINDING AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  26. PLACE OF DEATH (Check only one)  27. MANNER OF DEATH  Natural 5 Pending  28b. DATE OF INJURY  (Month, Day, Year)  24b. WERE AUTOPSY FINDING AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  24b. WERE AUTOPSY FINDING AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  26c. NJURY AT WORK?  1 YES 2 NO  27. MANNER OF DEATH  (Month, Day, Year)  28c. INJURY AT WORK?  1 YES 2 NO  28d. DESCRIBE HOW INJURY OCCURED									
3 Suicide 8 Could not be determined  28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)									
			at the time, date and place, and do			nenner as stated.			
296. SHINATURE AND TITLE OF CERTIFI	ER Lauh	ani	29c. LICENSE NO		d. DATE SIGNED (Month				
30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DEA	7 2 20	PARIC HE	Cotts AVE		MD212			

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hat the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

J by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should and Mental Hyghere prior to bunal, cremation, or removal.

In Indian, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DS, P.O. BOX 68760

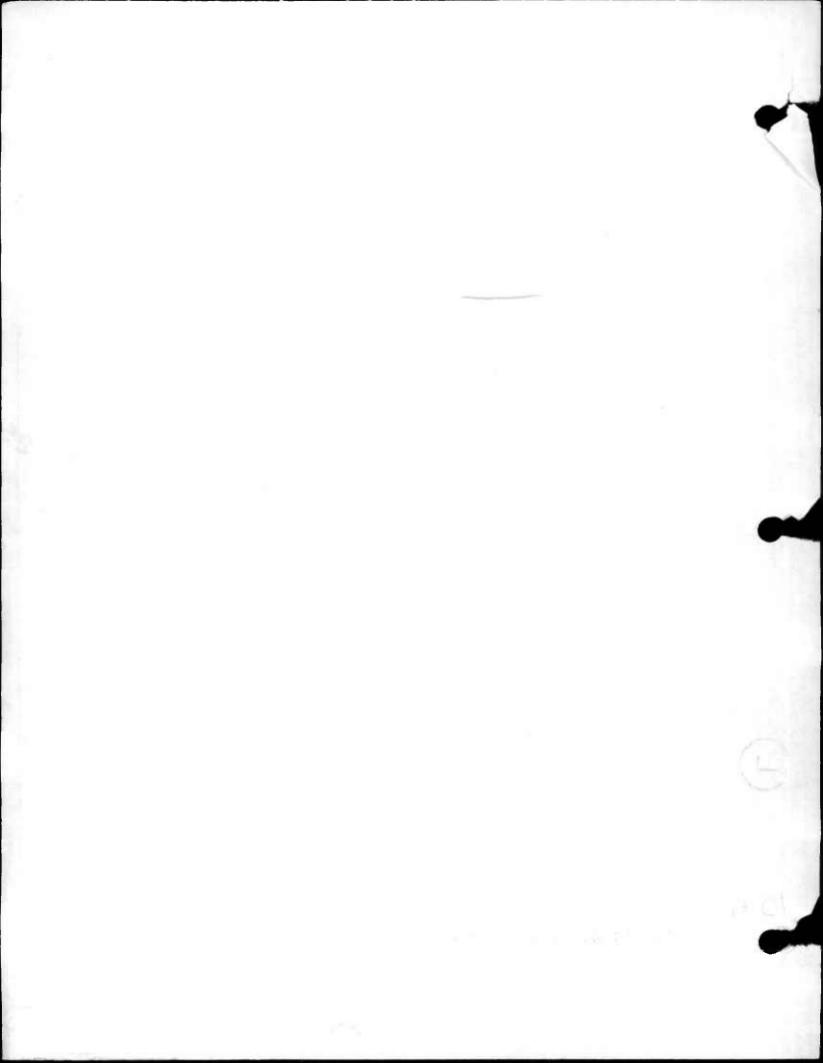
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DIVISION	TO THE HOSPITAL OR ATTENDING	TO THE FUNERAL DIRECTOR
1		1

31. DATE FILEO (Month, Day, Year)

32. REGISTRAR'S SIGNATURE

		FilmG, 72	3, it	em #12,	5/5	/95,	C	yw,	peı	c f.	h.			95		3272
_		1 - FOR STATE REGISTRAR		STATE OF I	MARYLA	ND / DE	PAR	TMENT	T OF H	EALTH	AND I	MENTAL	HYGIEN			
		1. DECEDENT'S NAME (Firs	t, Middle, Last)										OF DEATH			3. TIME OF DEATH
		Willard	(NMN)	Try	n							MONTH	N 1.	1995	YEAR	1:20 AM
		4. SOCIAL SECURITY NUM	BER	5. SEX		yrs. last birt	thday)	IF UNDER	R t YEAR	IF UNDER	24 HRS.	7. DATE	JE BIRTH			LACE (State or Foreign
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		9a. FACILITY NAME (If not it		treet and number)			-	9h CITY	/ TOWN O	R LOCATIO	ON OF DE	FATM				
ag	5	JOHNS HOPK	INS BAY		DICAL	CEN	TER			MORE		EATH		9c. COUNTY OF DEATH N/A		
DIBECTOR		10a. STATE		c, CITY	, TOWN	OR LOCAT							10d. INSIDE CITY LIMITS?			
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ELINEDAL		10e. STREET AND NUMBER	l						101.	ZIP CODI	-					HAT COUNTRY?
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	5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN	U.S. ARMEO		13.	WAS DEC	ENDENT O	F HISPAN	IIC ORIGIN	? (Specify Yes	or No-	14. RACE -	- American Indian,
		1 Never Married 2	1/2/11	FORCES? 1	MAR-OR DAT	ES NO			If yes, spe	E NO	n, Mexica Specifi	n, Puerto F	ican, etc.)		Black, Specify	White, etc.
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- C	3	15. OE	CEDENT'S EDUC	CATION	1	16a. DECED	ENT'S	USUAL O	CCUPATIO	N.		18b.	KINO OF BUS	SINESS/IND	USTRY	
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ONCE.		17. FATHER'S NAME (First, A	Airfello Lant)	-				-								
		SHERMAN	mode, East)	TRYON							SSIE		liddle, Maiden	Surname) HIPPO	A TUE	
E E	:			11(101)						יבכ	2011			HIFFC	)LIII	
		19a. INFORMANT'S NAME (	Type/Print)										er, City or Tow			
	1	MARY VIOL	A TRY	NC		822	SF	PRIN	GDALI	E DR	IVE,	MILI	ERSVI	LLE,	MD.	21108
	ı	20a. METHOD OF DISPOSIT	ION			LACEAND				me of		OATE	29c. LO	CATION -	City or Tow	n, State
	ŀ	4 Donation 5 Other		oval from State	MD	ary, cremato			CEME	TEDV		5686	CRO	WNSVI	LLE,	MD.
5	1	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE	FILE	· VIII	TilVe				SS OF FA			ON ET	INFRA	L HOME,
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3		23. PART I. Enter tha d	liseases, or c	omplications the	caused	be death.	Do no	ot antar	tha mod	da of dyl	ng, suc	h aa card	ac or reapl	ratory srr	est,	Approximate
		IMMEDIATE CAUSE (Fi	nesit fallure. I	List only one cau	ISO OF OC	b line.										Interval Between Onset and Death
	ł	disease or condition														Onset and Dastn
É	H	resulting in death)	7 ,	metas	(OR AS A C	, b(a	dd	er (	canc	cr						344
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ERTIFICATION		Sequentially list condit	tions,	DUE 70												
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2		cause. Enter UNDERLY CAUSE (Disease or Inju														
		that initiated events		OUE TO	(OR AS A C	ONSEQUEN	ICE OF	):								
;   E		resulting in death) LAS	" .	ı												
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[] ₹		PART II. Other significa	unt conditions	contributing to	death but	not resul	iting ir	the un	derlying	cause g	iven in	Part I.	24a. WAS AN PERFOR			WERE AUTOPSY FINDINGS
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PHYSICIAN: MEDICAL	1	DID TOBACCO U	ISE CONTR	BUTE TO CA	LISE OF	DEATH	YE	1 🗆 2	NO I	UNC	ERTAIN	V X				- 120 1 JOHN
₹		25. WAS CASE REFERRED T				. PLACE OF				0110	ENIZII	PAL				
	1	EXAMINER?		HOSPITAL:				OTHER	₹:							
≥		27. MANNER OF GEATH		1 Inpetient 2				-			sidence	6 🗆 Other				9
古			Pending	28a. DATE OF (Month, D		28	b. TIME		28c. INJU WOF			28d. OE\$6	CRIBE HOW I	NJURY OCC	UREO	
B A		2 Accident	Investigation					M	1 🗌 Y	ES 2 [	NO					
										ute Number,						
14	3 Suicide 5 Could not be datarmined building, atc. (Specify)  29s. CERTIFIER (Check only one)  2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated.															
٣		29a, CERTIFIER 1 X CERT	TIFYING PHYSIC	CIAN: To the best of	my knowled	ine donth -		1 44 65 - 6	- d-A			4-4				
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8				- On the basis of a		THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE S	ugation	, in my o	pinion, de	men occure	ed at the	time, data	and place, an	dua to the	cause(s)	and manner as stated.
BE (		296. SIGNATURE AND TITLE	OF CERTIFIER	.10		1	1	1		29c, LICE	NSE NUM	IBER		29d. DATE	SIGNED (A	Month, Day, Year)
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유		30. NAME AND AODRESS O	F PERSON WHO	COMPLETEO CAUS	E OF DEAT	H (ITEM 27)	(Туре, і	Print)	lobo	e Had	KIOS	Bou	ICH M			
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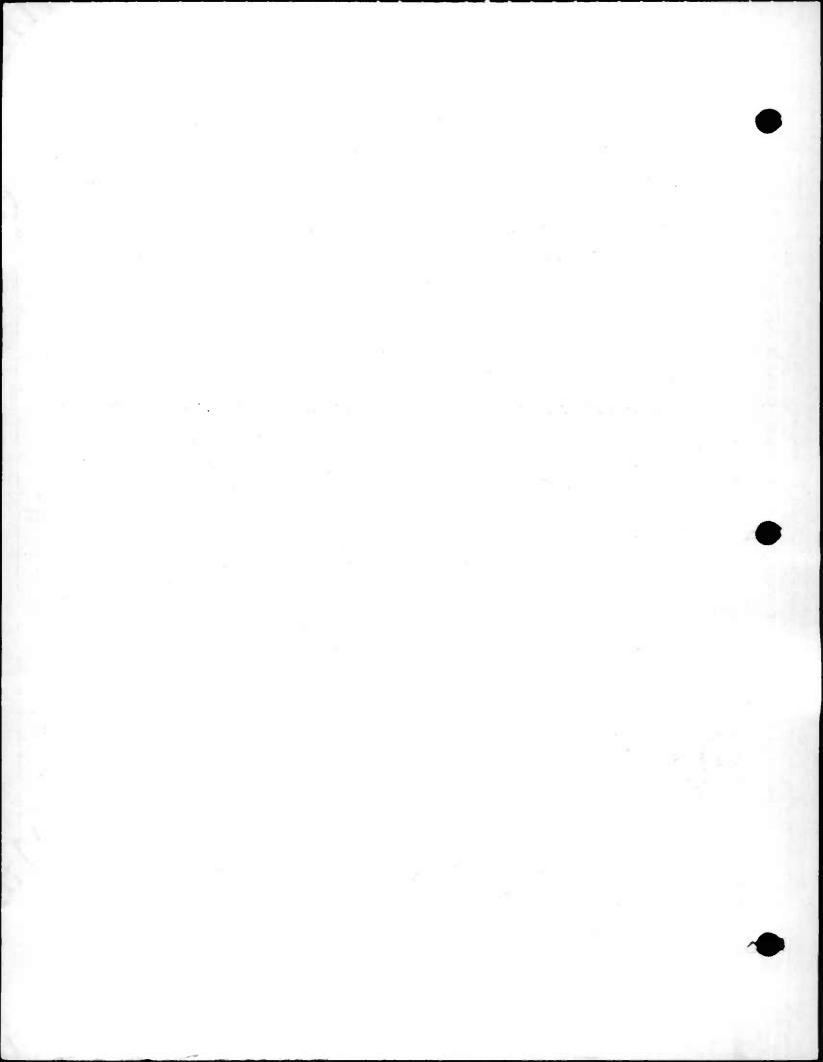


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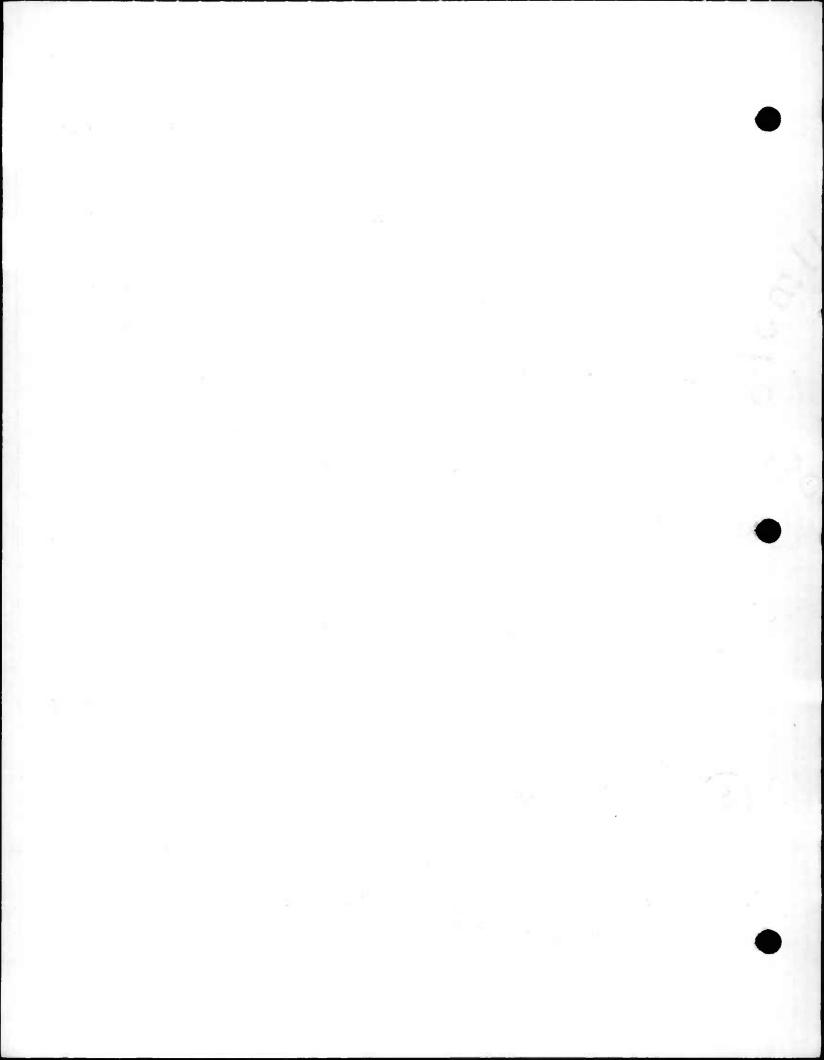
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. OECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ALICE APRIL 28 1995 ELIZABETH THOMAS 10:00 A. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 165-20-3541 1 🗆 M XX F 83 06-07-1911 PENNSYLVANIA Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 1225 BRANCH COURT GLEN BURNIE ANNE ARUNDEL RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND ANNE ARUNDEL GLEN BURNIE 1 YES AN NO permit. FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1225 BRANCH COURT 21061 U.S.A. detached for use as the burial-transit Page 6 may be retained by the hospital or attending physician. 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES YNNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YEXIN NO Specify: 14. RACE — American Indian, Black, White, etc. **BALTIMORE, MARYLAND 21215-0020** 1 Never Married 2 Married B Specify: 3 Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION 16a, OECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INOUSTRY (Give kind of work done life. Do NOT use retired.) st of working intary/Secondary (0-12) College (1-4 or 5 +) 6 NONE HOMEMAKER OWN HOME once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) **GEORGE BOGDON** HARDISKY page 5 should be to MARY BE notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAJLING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 MARGUERITE M. KENNEDY 1225 BRANCH COURT, GLEN BURNIE, MARYLAND 21061 Pe 20a, METHOD OF DISPOSITION
1 N Burlel 2 Cremation 3 Rei 4 hours after death, Page 6 may led in by the funeral director, part or removal. 20c. LOCATION - City or Town, State 5/19/95 must MARY'S NATIVITY CEMETERY 4 Donation 5 Other (Specify) PLYMOUTH TOWNSHIP, PA. examiner 21, SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY STAGLETON FUNERAL HOME, GLEN BURNIE, MARYLAND 21061 medical 23. PART i Enter the diseases, or complic ations that caused the death. Do not enter the mode of dying, auch as cerdisc or respiratory arrest, filled in by Approximate or heart fellure. List only one ceuse on each line. shock Interval Between IMMEDIATE CAUSE Finel Onset and Death cremation, the er condition disease emo completely resulting in death) event, TO (OR AS A CONSEQUENCE OF) and com traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): 2 if any, leading to immediate cause. Enter UNDERLYING attending physician 2 prior CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 signed by the atte Inlury PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 2 MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE Chebrovaccular 質 aleeden any 1 TYES 2 NO OF DEATH? requires shows 1 TES 2 NO C of P DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ Dept. ICIAN: À 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) ä E 利用 HOSPITAL: OTHER: 1 TYES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF OEATH 28e. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident 5 Pending М 1 YES 2 NO ATTENDING 3 Sulcide 28e. PLACE OF INJURY — At home, term, streel, fectory, office building, sic. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR A Nous after I tem 28 In 8 Could not be COMPLETED 4 Homicide determined 8 29a. CERTIFIER 1X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) end manner as stated. FUNERAL within 72 t HOSPITAL THE HOSPITA
THE FUNERA
Fled within 7. ition and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. IS SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, 0389 2 2 3 3 2 E AND ADDRESS OF PERSON QE DEATH (THEM 27) (Type, Print) ·D Dae 31. DATE FILED (Month, Day, Year) MAY 0 2 1995 Davidson Randall 0 2 1995



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DIVISION OF VITAL RECORDS, P.O. BOX 68760	recuted	and has
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		1. DECEDENT'S NAME (First, Middle, I	R. Thomp							MONT	OF DEATH		YEAR 3	TIME OF DEATH	
뭐	3	4. SOCIAL SECURITY NUMBER 213–36–4368	5. SEX 1 □ M 2/2008	11	(In yrs. lest birthd	MO	NTHS DAY		R 24 HRS.	7. DATE (Mont) Jun	OF BIRTH	09	Mary	ACE (State or Foreign land	
2, 3 should	стов	99. FACILITY NAME (If not institution, give street and number)  1. Lorien Nursing Home  1. Residence of peccepti													
. Pages 1,	DIREC	10e. STATE 10b. CO		10c.	10c. CITY, TOWN OR LOCATION 10d. INSIGE EMITS:								Dd. INSIDE CITY LIMITS?  YES 2 NO		
ısit permit.	FUNERAL I	100. STREET AND NUMBER 3871 Old Columb						101. ZIP COD	DE .					AT COUNTRY?	
215-0020 attending physician. ise as the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 XXWIdowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	T EVER	YES 2-1-NO It yes, specify Cuben, Mexica					nn, Puerto Rican, atc.) Bia			4. RACE — Black, V Specify:	American Indian, White, etc.	
. 6 .	COMPLETED	15, DECEDENT'S (Specify only highest Elementery/Secondary (0-12)	(specify only highest grade completed)  Elementery/Secondary (0-12) College (1-4 or 5+)						e. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  OSTESS  166. KIND OF BUSINESS/INDUSTRY Funeral Home						
HYLAND We by the hospital bid be detached to ad at once.	BE COM	17. FATNER'S NAME (First, Middle, Lest) Harry Lee Cross  18. MOTHER'S NAME (First, Middle, Meiden Surname) Eva Mae Ridgely													
retain 5 sho	10 6	19a. INFORMANT'S NAME (Type/Print) Ms. Doris T. Sl	ack		196. MAJL 3864	NG AOI	DRESS (Stre Ld Co	et and Numbe Lumbia	or Rural R	e, E	oor, City or Town	State, Zip C	y, M	D 21043	
Page 6 may be ral director, page		20e. METHOD OF DISPOSITION   C  Burlel 2   Cremetion 3   4   Donation 5   Other (Specify)			b. PLACE AND DA melery cremetory MOUNTA		view	Cemete			95 Mar	riott	ty or Town. SVil	le, MD	
r death.	1/20	22. NAME AND ADDRESS OF FACILITY Slack Funeral Home, P.A. Ellicott City, Maryland 21043  23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate													
8. ∰ S ₩		23. PART I. Enter the diseases, ahock, or heart felic immediate CAUSE (Final disease or condition resulting in death)	or complications that use. Liet only one ceu	ise on e	eech line.		enter tha	moda of dy	ring, auch	n aa cerd	liac or respir	atory arres	nt,	Approximate Interval Between Onset and Death	
executed and compared burial, matter en	TION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING  CAUSE (Observed Labora).  SHASE FOUR decularities ulceration—  SUE TO (OR AS A CONSEQUENCE OF):  SHASE FOUR decularities ulceration—  SUE TO (OR AS A CONSEQUENCE OF):  SHASE FOUR decularities ulceration—  SUE TO (OR AS A CONSEQUENCE OF):											3 months		
e phy	CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  Junobi Pit.  Due TO (OR AS A CONSEQUENCE OF).  d. Multi un Favet dementia									3 months months 5+yeas.				
that the ed by the th and Me	MEDICAL CE	PART II. Other algnificent cond									24a. WAS AN A PERFORM 1 YES 2	AED?	AM CO	ERE AUTOPSY FINDINGS AILABLE PRIOR TO DMPLETION OF CAUSE	
law requires that has been signed Dept. of Health a 23 shows any		DID TOBACCO USE CO	NTRIBUTE TO CA	USE C	OF DEATH	YES [	□ NO	D UNC	CERTAIN					TEATH? TYES 2 NO	
PHYSICIAN: The law The certificate has The state Deprivate the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state o	YSICIAN:	25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO	HOSPITAL:	ER/Out	26. PLACE OF D	GJ	THER:	iome 5 🗆 Re	esidence (	6 🗆 Other	(Specify)				
	зу РН	27. MANNER OF OEATH  1 Natural 5 Pending 2 Accident Investigati	26e. DATE OF (Month, D			IME OF		INJURY AT WORK?	□ ND	28d. DE\$	CRIBE NOW IN	JURY OCCU	REO		
A ATTENDING	1	3 Suicide 6 Could not 4 Nomicide determine	building.	F INJURY etc. (Spec	f — At home, terr cify)	n, street	it, fectory, o	ffice		281, LOCA City o	ATIDN (Street en or Town, State)	nd Number or	Rural Rout	a Number,	
THE HOSPITAL OR THE FLWERAL filed within 72 cours	сомы		HYSICIAN: To the best of MINER: Dn the basic of ex											id menner ee stated,	
TO THE HOSP TO THE FUNE TO Filed within	O BE	296. SIGNATURE AND TITLE OF CERT	Colule	ile	4			29c. LIC	315	BER 2-5		29d. DATE S	IGNED (MC	onth, Day, Year) 8/95	
6		30. NAME AND ADDRESS OF PERSON	573	852	01 01	rpe, Print	An	apol	les R	sclo	( 811.	woll.	Cety	21042	
		MAY U 2 1995	Julia Dienos	R'S GIGN	T.II.			,					1		



	1. DECEDENT'S NAME (First, Middle, Lest)  Natthew Jason Temple  2. DATE OF DEATH DAY APRIL 23, 1995 5:00a											VEAC :	3. TIME OF DEATH
		-							April	23,	. 19	95	5:008
	4. SOCIAL SECURITY NUMBER 218-21-2824	5. SEX	6. AGE (In y	rs. lest birthday)	IF UNDER	YEAR DAYS	IF UNDER	24 HRS.	7. DATE OF BII	HTH Year)		Country)	LACE (State or For
	90. FACILITY NAME (If not institution, give			YRS.	Oct.6,1987 Maryla								
E.	John Hopkins		1		96. CITY, TOWN OR LOCATION OF DEATH  Baltimore City  Baltim								
CTC	RESIDENCE OF DECEDENT								СУ	-y   Baltin			ore Cit
DIRECTOR		ARundel			ownsville					IOd. INSIDE CITY LIMITS? I X YES 2			
FUNERAL	907 Indian C	reek Lan	е				2 1032		-		US.		IAT COUNTRY?
B⊀	11. MARITAL STATUS  11. Never Merried 2 Merried  3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2	2 JNO	It yes, specify Cuben, Maxicen, Puerto Ricen, etc.) Bleck, White,					American India White, etc. White			
	15. DECEDENT'S ED (Specify only highest gra	DUCATION de completed	18	e. DECEDENT'S (Give kind of	USUAL OC	CUPATIO	ON .		16b. KINO	OF BUSIN	NESS/INOU	JSTRY	
COMPLETED	Elementary/Secondery (0-12)	College (1-4 or 5 +	)	Ille. Do NOT us	se retired.)	ining mo	st or workin	g		_	,		
MP	Special Ed.  17. FATHER'S NAME (First, Middle, Last)			Stude	ent						hoo	1	
	James J. Temp	le Jr.						MOTHER'S NAME (First, Middle, Melden Surname)  (aren Owens					
BE (	Mac INFORMANTIC NAME OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STA								State Zin (	Code)			
٩	James J. Temple Jr. 907 Indian Creek Lane, Crownsville, MD 210												
	20a. METHOD OF DISPOSITION 11 Burlal 2 ☐ Cremation 3 ☐ Re	movel from State	20b. PL	ACE AND DATE	OF DISPOSI	TION (Na	me of		DATE	20c. LOCA	TION — C	ity or Town	n, State
	4 Donation 8 Other (Specify)		H1.	ilcres					4/26	An	nap	olis	, MD
	21. SIGNATURE OF PUNERAL BERVICE (	CENSEE /	1///				D ADDRES		neral	Hom	ie. I	р. д	
	· Valenche	y cernal	1/1						Ave. A				
TIFICATION	23. PART i. Enter the diseases, pr shock, pr heart failure IMMEDIATE CAUSE (Final	complications that List only one caus	ceused the	e deeth. Dp r	not enter	he mo	de of dyl	ng, such	as cardiec D	r respirat	tory arre	et,	Approxima
	disease or condition resulting in death)	. 4545	TOLE										Interval Be Onset and
ERTIFICATION	diseese or condition	a. A SYS  DUE TO (  DUE TO (  FORE  DUE TO (  d.	TOCE OR AS A CO OR AS A CO OR AS A CO	BODY	FAD TIS AS A	I.C.	NJC TION	PR(	nlone )VED	-0C	y.W.	ng ht	Interval Be Onset and
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32. REGISTRAR'S SIGNATURE
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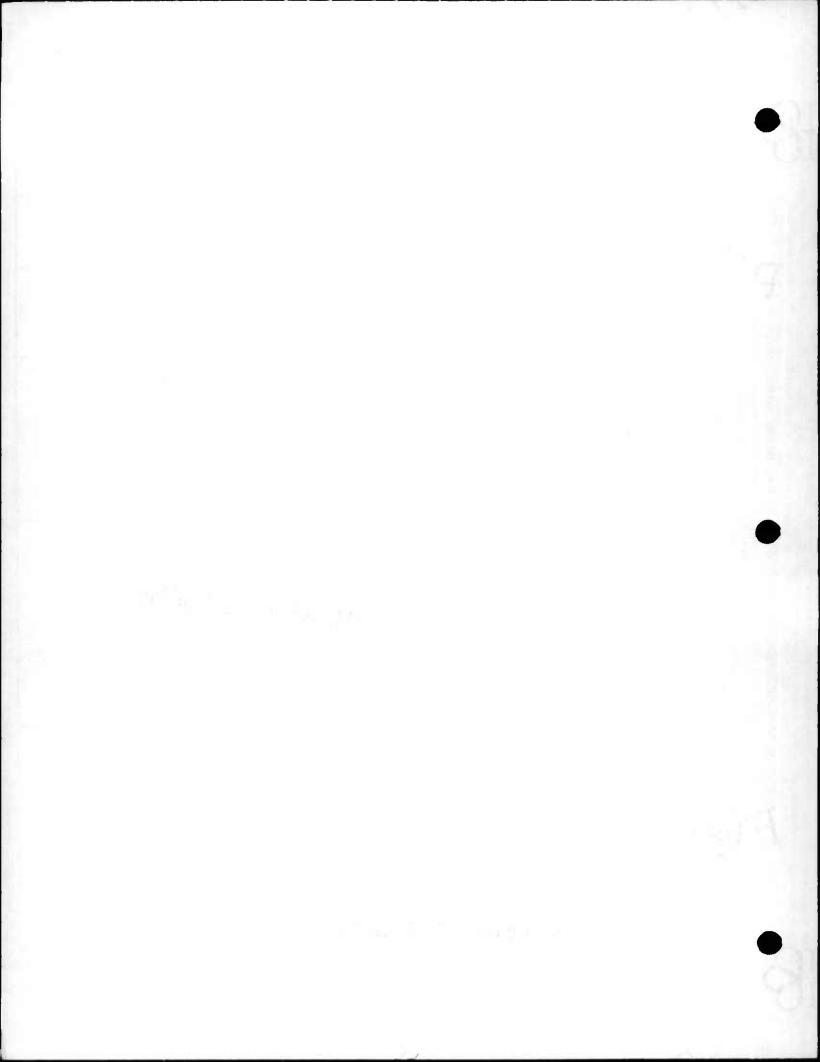
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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31. DATE FILED (Month, Day, Year)



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		REGISTRAR				F DEATH		REG. NO			
<b>A</b>		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATH	MY Y	3. TIME O	F DEATH
		Doris Dawson T		n yrs. last birthday)	er invoen a verse						
pin		434-32-4514  9e. FACILITY NAME (If not institution, give a	1 🗆 M 2 🔀 F	66 YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	Sep	t. 30	,1928		siana
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physician. bunal-transit permit, Pages 1,	DIRECTOR	10e. STATE 10b. COUNT	Arundel	An	y, town or Loc napoli	S				10d. INSID LIMIT 1 YES	
n. ansit perm	FUNERAL	706 Tyler Ave				21403			10g. CITIZEI	OF WHAT COUN	ITRY?
	BY	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 NO	II yes,	ECENDENT OF HISPAI specify Cuben, Mexico ES 2 NO Specif	en, Puerto	Y? (Specify Yes Ricen, etc.)	e or No— 14	RACE — America Black, White, etc Specify: W	en Indian, c. nite
or att	COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 1 2	CATION completed) College (1-4 or 5+)	life. Do NOT us	work done during	TION most of working			siness/indus		
d by the hospitud be detached	i m	17. FATHER'S NAME (First, Middle, Last) Antonio Van Vo	ras			18. MOTHER'S NA Alice	ME (First, i	Middle, Maiden	Sumeme)		
e 5 should be notified		19a. INFORMANT'S NAME (Type/Print)  Janice D. Simm	ons	19b. MAILING	ADDRESS (Stree	t and Number or Rural			n, State, Zip Co		
e 6 may be ector, page		20a. METHOD OF DISPOSITION 1 □ Burlel 2 □ Cremation 3 □ Rem 4 □ Donation 6 💢 Other (Specify) 上力	oval from State	PLACE AND DATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STA	ther place!		4/2	E 20c, LO	CATION - City	or Town, State	D
hours after death. Page 6 may be retained by the funeral director, page 5 should be or removal.  Tredical examiner must be notified at medical examiner must be notified at		21. SIGNATURE OF FUNERAL SERVICE LIK			22. NAME Har	AND ADDRESS OF FA desty Fi Ridgely	uner	al Ho	ome, I	.A.	
ely fill artion.		23. PART i. Enter the diseases, or check, or heart fisiture.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Examplications that caused List only one cause on each of the cause on each of the cause on each of the cause on each of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause	ch line. .ε ΜΥ,	ELOMA	node of dying, auc	h as csro	diec or respi	iratory arrest	, App inter One	roximate rvai Between st and Death
executed and con to burial, matic en	CATION	Sequentielly list conditions, if any, issding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR AS A (								
death certificate be attending physician ental Hygiene prior b	ERTIF	that initieted events resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF	F):						
the d We dimin	OICAL	PART ii. Other eignificent condition	e contributing to death bu	t not resulting	in the underlyl	ng ceuse given in	Part i.	24a. WAS AN PERFOR 1 YES 2	RMED?	24b. WERE AUTO AVAILABLE COMPLETIC OF DEATH? 1 YES	PRIOR TO ON OF CAUSE
has been Dept. of 23 sh	A	DID TOBACCO USE CONTI	20	DEATH YE	TH (Check only on		N 🗆			, , , ,	
ician: The ertificate is the State	YSIG	1 TES 2 NO	1 M inpetient 2 ER/Outpet	tlent 3 🗆 DOA	OTHER: 4 Nursing Ho	me 5 🗆 Reeldence	6 🗌 Othe	r (Specify)			
NG PHYSIC fler this ce sath with the	1 1	27. MANNER OF DEATH  1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	26b. TIM INJ	URY	JURY AT YORK? YES 2 NO	28d. DES	CRIBE HOW I	NJURY OCCUR	EO	
		3 Suicide 6 Could not be determined	26s. PLACE OF INJURY - building, atc. (Specif)	At home, farm, a	street, factory, off	Ice	26f. LOC. City	ATION (Street of or Town, State)	and Number or I	Rural Route Number	c
ED ON PORTE	COMPLE		CIAN: To the best of my knowles R: On the basis of examination							suse(e) and manne	or on stated
255	BE CC	296 SIGNATURE AND TITLE OF CERTIFIE				29c. LICENSE NUM		,		GNED (Month, Day	

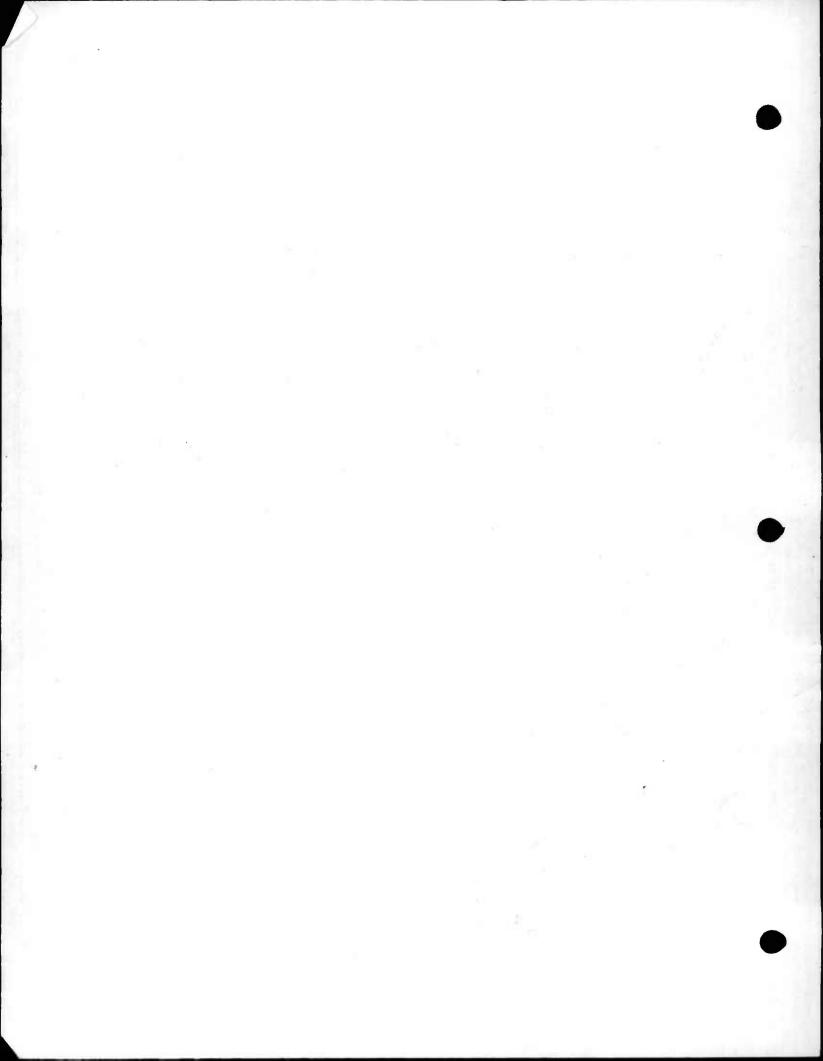
GEATH (ITEM 27) (Typo, Print)
GOO Bestgate

32 REGISTRAR'S OGNATURE

Road

Sute 300

Annapoliu, MD 21401



3. TIME OF DEATH

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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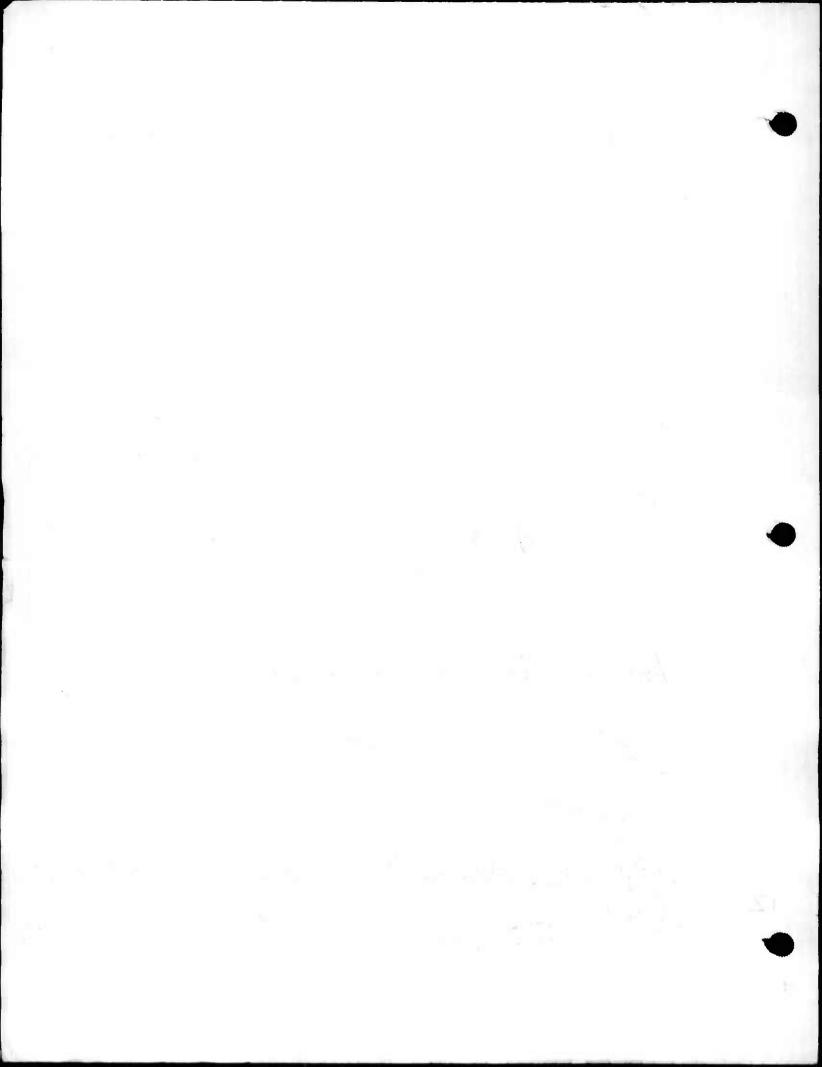
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1240A IA ANSON ADRIA 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 3 M 2 F YRS. March 3, 1912 Nebraska 716-01-8285 permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF OEATH 9c. COUNTY OF DEATH DIRECTOR Chesapeake Manor Nursing Home Anne Arundel Arnold 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10a STATE 10d. INSIDE CITY 1 YES 2 X NO Arnold Anne Arundel FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? be retained by the hospital or attending physician. as 5 should be detached for use as the burial-transit USA 21012 659 Southern Hill Drive 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—if yea, specify Cuben, Mexican, Puerto Rican, etc.)
1 YES 2 MO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married
3 Widowed 4 Divorced Specify: BY White ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16h KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Chief Mechanical Officer Trailer Train 17 FATHER'S NAME /First Middle | not) 16. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Anna Marie Eacritt Ross Van Valkenburg Taylor n and completely filled in by the funeral director, page 5 should to burlal, cremation, or removal. 19 a. INFORMANT'S NAME (Type/Print) 19b. MAILINO AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 658 Southern Hill Drive, Arnold, MD 21012 Mrs. Ellie B. Taylor å 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) 20c. LOCATION — City or Town, State must Baltimore, MD Metro Crematory, Inc. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY examiner Du Illian McCully Funeral Home of Pasadena, MD Junes Steven H. Williams 3204 Mountain Road 21122 medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximete shock, or heart failure. List only one cause on sech lins. interval Between Onaet and Daeth IMMEDIATE CAUSE (Finel farction the disease or condition resulting in death) event, traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING the attending physician I Mental Hygiene prior to CAUSE (Disease or injury other OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST injury, or PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL been signed by the of Health and N AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any 1 | YES 2 | NO 1 TYES 2 NO PHYSICIAN: State Dept. 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item this certificate 1 TYES 2 THE OTHER: OR ATTENDING PHYSICIAN: 1 | Inpatient 2 | ER/Outpatient 3 | DOA ng Home 5 - Residence 6 - Other (Specify) marked, or the 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c, INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCUREO 26b. TIME OF INJURY with 1 1 Natural TO THE HOSPITAL OR ATTENDING PH TO THE FUNERAL DIRECTOR: After this be filed within 72 hours after death wi IMPORTANT: If Item 28 is marke 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 8 Could not be 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 29b. RIGNATURE AND TITLE OF CERTIFIES 29d. DATE SIGNED (Month, Day, Year) BE 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CRAIN HWY \$ 106 1600 2106, 32 REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

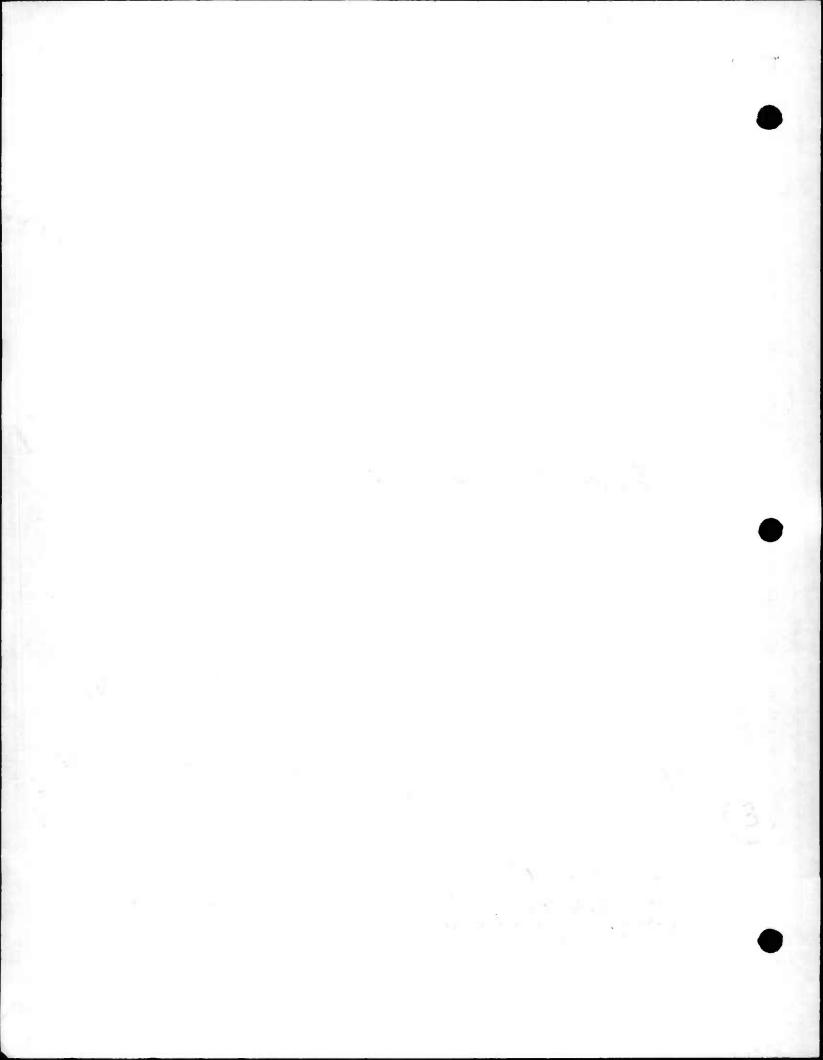
CERTIFICATE OF DEATH

2. DATE OF DEATH



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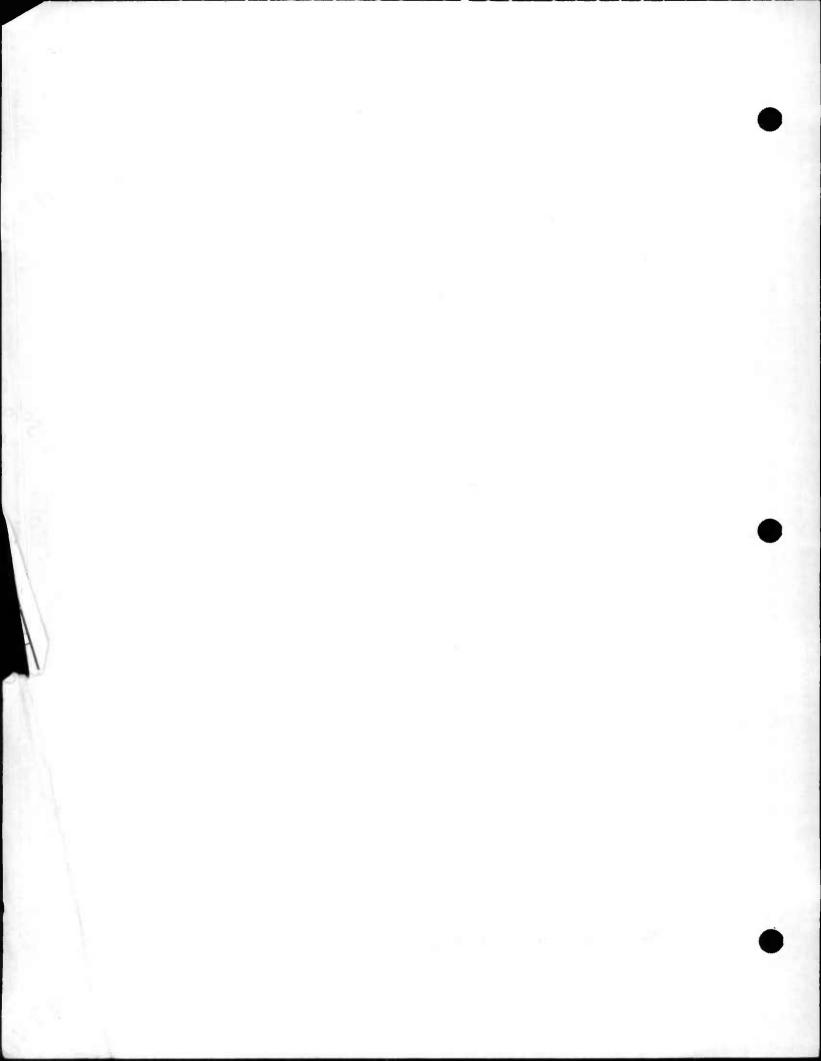
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		FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	TMENT OF	HEALTH AND W	IENTAL HYGIEN					
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	DAY YEAT	3. TIME OF DEATH			
		SAMUEL THOME	201.					23,1995				
		4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		RTHPLACE (State or Foreign untry)			
		219-35-5845	1 🖟 M 2 🗆 F	6 YRS.			Aug. 21, 1		ltimore, Md.			
	R	96. FACILITY NAME (If not institution, give s EASTON MEMORIA	treet and number) L HOSPITAI		EAST	OR LOCATION OF DEA	9c. COUNTY O					
	DIRECTOR	RESIDENCE OF DECEDENT							-			
ı	H	Manager 10b. COUNTY			Y, TOWN OR LOC	ATION			16d. INSIDE CITY LIMITS?			
		Maryland Harf	ora		BelAir				1 YES 2 X NO			
	FUNERAL	106. STREET AND NUMBER			13	of. ZIP CODE			F WHAT COUNTRY?			
- 1	NE.	819 Comer Square	12 WAS DECEDENT SUPPLY	N. II.O. ADIECO	10 110 0	21014			S.A.			
		1 Never Married 2 Married	12. WAS DECEDENT EVEN I FORCES? 1 YES	2 X NO	If yes, s	CENDENT OF HISPANICAN, Mexican,	Puerto Rican, etc.)	s or No — 14. P.	ACE — American Indian, lack, White, alc.			
- 1	B	3 Widowed 4 Divorced	IF YES, GIVE WAR ON D	ATES	1 _ YE	S 2 (X NO Specify:			^{∞c/ly:} √hite			
	윤	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S	USUAL OCCUPAT	TION	16b. KIND OF BU	ISINESS/INDUSTR				
	Ē	Elementary/Secondary (0-12)	College (1-4 or 5+)	We. Do NOT us	se retired.)	lost of working	1					
9	COMPL	17. FATHER'S NAME (First, Middle, Last)		N/	А		N/A					
at once.	- 1	John Thompson				1	E (First, Middle, Maiden	Surneme)				
Pe	BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	and Number or Rural Ro	Jra Ely	um State Tie Code)				
noti	임	John Thompson			Comer S		elAir, Md					
examiner must be notified	- 1	20a. METHOO OF DISPOSITION 1X Burlel 2 Cremation 3 Rem	201	D. PLACE AND DATE O	OF DISPOSITION //	Name of	DATE 20c LC		Town, State			
Ē		4 Donallon 5 Other (Specify) Camelery, Crangelory or other place   Upper Cross Roads Baptist Cem. 4/26/95   Baldwin, Maryland										
튙	- 1	21. SIGNATURE OF FUNERAL SERVICE LIC	//	1	22. NAME AND ADDRESS OF FACILITY							
		E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, Md. 21087										
medical		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate										
E		IMMEDIATE CAUSE (Finel )										
event, the		disease or condition resulting in death)	Drown	up								
Š			DUE TO (OR AS )	CONSEQUENCE OF	F):							
other traumatic	RTIFICATION	Sequentielly list conditions, If any, leading to immediate	DUE TO (OR AS /	A CONSEQUENCE OF	7):							
tra	CAT	ceuse. Enter UNDERLYING			,				İ			
the	F	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS /	A CONSEQUENCE OF	7):							
6	ш	resulting in death) LAST	d									
injury,	LC	PART ii. Other aignificent condition	s contributing to death b	out not resulting i	n the underlyis	ng ceuse given in P	art i. 24s. WAS AN	AUTOPSY	4b. WERE AUTOPSY FINDINGS			
any i	EDICAL						PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
shows	MED						-   X 1ES :	2 🗆 NO	OF DEATH?			
23 sh		DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	F DEATH YE	S I NO [	UNCERTAIN			1 YES 2 NO			
item 2	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEAT	H (Check only one							
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	PHY	27. MANNER OF DEATH  1 Natural 5 Pending	(Month, Day, Year)	28b. TIMI		JURY AT ORK?	28d. DESCRIBE HOW	INJURY OCCURED	1-00			
	B	Accident Investigation	260 PLACE OF INJURY	592	4	YES 2 NO	Subject	- drows	ud ott			
25		3 Suicide 8 Could not be 4 Homicide detarmined	building, atc. (Spec		treet, fectory, offi -	ce	28f. LOCATION (Street City or Town, State)		al Reule Number,			
Y	9 1	29a. CERTIFIER		ades			Chaptart 1	seven In-	rellet Carlo			
ŧ	COMPLETED		CIAN: To the best of my know R: On the basis of examination						may and			
=	ECC	29b. SIGNATURE AND TITLE OF CERTIFIER		/	, , , , , , ,			and the second				
MPO	0	Theodoro	Mr King	1 -1	29C. LICENSE NUMBER O. C. M. E				29d. DATE SIGNED (Month, Day, Year)  ▶ APRIL 24, 1995			
	일	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE									
		I HE ED ARE A	4.Kpe 1		Stree	t, Balti	more, Ma	aryland	21201			
1		MAY U 2 1995	A REGISTRAN RIGH	ATT.								



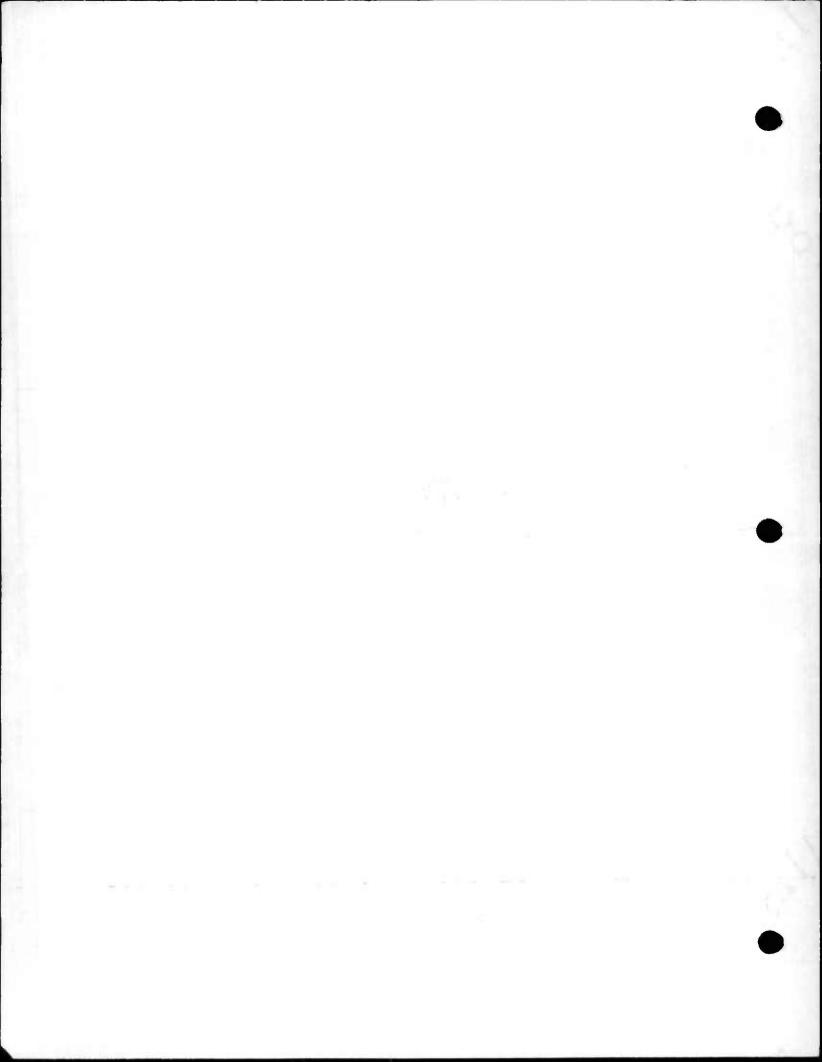
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		1 - FOR STATE REGISTRAR  1. DECEDENT'S NAME (First, Middle, Last)	STATE OF MARYL	AND / DEPA CERTIF	RTMENT OF FICATE OF	HEALTH AND DEATH		REG. NO.	E			
		GEORGE	WR	1947	JR.		2. DATE OF MONTH	OEATH DA		AR	IME OF DEATH	
_		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, L	Day, Year)	0. E	INTHPLAC	CE (State or Foreign	
should		217-14-6642  9a. FACILITY NAME (If not institution, give str		72 YRS.	9b. CITY, TOWN	OR LOCATION OF D	March	1,	1923 N	MARYL		
, 3 sp	OR	NORTH WEST HOSPITA						BALTIN				
Pages 1,	RECTOR	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY		10c. Cf	10c. CITY, TOWH OR LOCATION					10d	. INSIDE CITY	
permit. Pa	ā		TIMORE CITY		BALTIMORE CITY					ΧD	LIMITS? YES 2 NO	
	ERAL	100. STREET AND NUMBER 2259 MADISON AVEN	HE 2nd Floor	r	1	01. ZIP CODE 21217			10g. CITIZEN		COUNTRY?	
-0020 ing physician. the burial-transit	FUNI	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES	N U.S. ARMED	13. WAS DE	CENDENT OF HISPA	NIC ORIGIN?	Specify Yea	or No.— 14. I	_	merican Indian,	
215-0020 attending physic use as the burial	BY	1 Never Married 2 Married 3 Wildowed 4 XXDIvorced	WORLD WAR	ATES		S 2X NO Specif		un, etc.j		Specify:	BLACK	
r attending use as the	TED	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION	16a. DECEDENT'S	S USUAL OCCUPAT		16b. K	NO OF BUS	SINESS/INDUSTI		) L / 10 K	
ND 21 hospital or ached for u	PLET	8th grade	College (1-4 or 5+)	Δuto T	echican			LIMIZ	NOWN			
A at the	COMPL	17. FATHER'S NAME (First, Middle, Last)		- Adico i	ech rean	18. MOTHER'S NA	AME (First, Mid					
Z 2 2 2	ш	George Wright  19a. INFORMANT'S NAME (Type/Print)				Carrie						
be retained ge 5 should		Venessa Wright				end Number or Rural					and 21061	
H e e		20a. METHOD OF DISPOSITION 1 (V Burial 2 Cremation 3 Remove	All from State   con	PLACE AND DATE	OF DISPOSITION	vame of	OATE	20c. LO	CATION - City	or Town, S	State	
		4 Donation 8 Other (Specify)	M/	ARYLAND	VETERANS 22. NAME	CEMETER	ACILITY				<u>laryland</u>	
m - 2 m		Thankett for	Ell		1206	IAM C. B W. Nort	h Aver	nue		′H		
hours afte ed in by th or remove		23. PART I. Entar tha diseases, or co ahock, or heart failure. L	emplications that cause ist only one cause on a	d tha death. Do each line.	not enter tha m	oda of dying, suc	ch as cardia	c or reepi	ratory srreet,		Approximate interval Batween	
ation.		iMMEDIATE CAUSE (Final disesse or condition resulting in death)	SEP.	515							3 DA S	
760 complete al, crem		and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s		CONSEQUENCE C	OF):				ı		3017 3	
OX 687  e be executed sician and con infor to burial, traumatic a	NOI	Sequentially liet conditions, if any, leading to immediate	if any, leading to immediate									
BO icate be physician in prior	ICA	cause. Enter UNDERLYING CAUSE (Disease or injury										
the death certificate the attending physical discussions or other the injury or other the		that initisted events resulting in death) LAST		CONSECUENCE	r-).					į		
at the death by the atter and Mental		PART ii. Other significant conditions	contributing to death b	out not resulting	in the underlying	ng ceuse givan in	Part i. 24	la. WAS AN	AUTOPSY	24b. WER	E AUTOPSY FINDINGS	
S S S S S S S S S S S S S S S S S S S	. S							PERFOR	-	COM	LABLE PRIOR TO PLETION DF CAUSE DEATH?	
w requires the been signed of Health are shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the shown and the sho	MEDI		T CALLET O			<b>-</b>					YES 2 NO	
Sa law	SICIAN:	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF OEA			иПТ					
VII.  SIAN: The critificate he State	YSIC	1 TYES 2 NO	HOSPITAL: 1 Pinpatient 2 ER/Outp	patient 3 🗆 DOA	OTHER: 4 Nursing Ho	me 5 🗆 Residence	8 - Other (S	ipecify)				
NG PHYSIC fifer this ce eath with the marked	PHY	27. MANNER OF DEATH  1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIN	JURY W	JURY AT ORK? YES 2 NO	28d. DESCR	IBE HOW II	JURY OCCURE	D		
7 2 4 5 "		2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Spec	— At home, ferm,			281. LOCATI	ON (Street a	nd Number or Au	ıral Route	Number,	
DR ATTENE DIRECTOR: hours after	: I iu I	4 Homicide determined			-				<u> </u>			
4 7 Z	1 25 1	(Check only 1 CERTIFYING PHYSICI	AN: To the beat of my know On the basis of examination							use(e) and	manner as stated.	
TO THE HOSPIT TO THE FUNERA De filed within 7	BE C	296. SIGNATURE AND TITLE OF CERTIFIER	0.171.0			29c. LICENSE NUI			29d. DATE SIO			
2 2 3 3	2	30. NAME AND ADDRESS OF PERSON WHO		ATH (ITEM 27) (3m)	Print	043	462	-	► A P	2	8,1995	
11		K.S.RAO.M.	O NORTH	HODALC	-JTOWA	L CEN	TER					
111		31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE				_				
	لـــا	MAY 0 2 1995	Vi Muchant	white							DHMH-16 Rev 1/89	



		1 - STATE REGISTRAR	STATE OF MARYLA		TMENT OF I		MENTAL HYGIE			
		1. DECEDENT'S NAME (First, Middle, Lest) LEO PAUL WALSH					2. DATE OF DEATH MONTH APRIL 28,		YEAR 3.	TIME OF DEATH 3:55 A. M
Pir		4. SOCIAL SECURITY NUMBER 124-20-3400	1 🔀 M 2 🗆 F	n yrs. last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) JUNE 30, 19	8.	BIRTHPLA Country) W YOR	ACE (State or Foreign
1, 2. 3 should	CTOR	90. FACILITY NAME (If not institution, give sti  LAUREL REGIONAL HOSP  RESIDENCE OF DECEDENT				or Location of Di aurel	EATH	9c. COUNTY PRIM	Y OF DEAT	
permit. Pages 1	DIRE	10e. STATE 10b. COUNTY MARYLAND P	PRINCE GEORGE	10c. CITY	Y, TOWH OR LOCAL	TION AUREL				d. INSIDE CITY LIMITS? X YES 2 NO
isi.	NERAL	14921 LAUREL OAKS LA				4. ZIP CODE 20707		10		T COUNTRY?
21215-0020 al or attending physician. for use as the bunal-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2/(X) Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 NO	If yes, sp	DENDENT OF HISPAN Hecity Cuben, Mexice B 2 X NO Specify	HC ORIGIN? (Specify ) in, Puerto Rican, etc.)	ee or No—	I. RACE — Black, W Specify:	American Indian, hite, etc. WHITE
	ETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)		16a. DECEDENT'S I (Give kind of w life. Do NOT use	rork done during mo		16b. KIND OF B	USINESS/INDUS	TRY	
	COMPLET	12	2	FIREFIGH	ITER			ORK FIRE	DEPAR	TMENT
YLAN by the hos be detach at once.	ш	17. FATHER'S NAME (First, Middle, Lest)  JOHN J. WALSH					ME (First, Middle, Meide ANN CURREN	n Surname)		
MARYLAND  e retained by the hospit  5 should be detached notified at once.	TO BI	190. INFORMANT'S NAME (Type/Print)  CLATRE WALSH				and Number or Rural I	Route Number, City or To		ode) 0707	
MORE, le 6 may be rector, page must be r		20e. METHOD OF DISPOSITION 1 General Buriel 2 Comments General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General General	oval from State came	PLACE AND DATE O etery, cremetory or oth LTIMORE WA	F DISPOSITION (No	ame of	DATE 20c. I	JREL, MAR	y or Town,	
ALTIN r death. Pag e funeral dia ii.		21. BIGNATURE OF FUNERAL SERVICE CIC	De Coal	Q	760	1 SANDY SP	FLECK F	FUNERAL H	HOME,	INC.
wit 24 hours ely filled in thation, or re-		23. PART I. Enter the diseases, or contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained	Nu ptured	En flor	\			piratory arrea	t,	Approximate interval Between Onset and Death
687 xecuted and com burial, tatic en	CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING		CONSEQUENCE OF		/				
P.O. Entitical tending phy all Hygiene I	CERTIFICATION	CAUSE (Disease or injury that initiated eventa resulting in death) LAST	DUE TO (OR AS A (	CONSEQUENCE OF	):					
OF VITAL RECORDS, F HYSICIAN: The law requires that the death this certificate has been signed by the attei with the State Dept. of Health and Mental ked, or Item 23 shows any Injury, or	MEDICAL C	PART II. Other eignificant conditions Hypertens	4	it not resulting in	n tha undariyin	g cause givan in		N AUTOPSY PRMED?	AWA CDI OF	RE AUTOPSY FINDINGS ILLABLE PRIOR TO MPLETION OF CAUSE DEATH?  YES 2 NO
AL R le law re has beer Dept. of		DID TOBACCO USE CONTR				UNCERTAIN	1 🗆			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
F VITA SICIAN: The certificate ha the State D the State D	PHYSICIAN:	EXAMINER?	HOSPITAL: 1 Minpetient 2 ER/Outpet		OTHER:	e 5 🗆 Residence	6 Cher (Specific)			
PHYSICIAN: This certifical with the Str inked, or It	E	27. MANNER OF DEATH  1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	26b. TIME INJU	OF 28c. INJ	URY AT	28d. DESCRIBE HOW	INJURY OCCUP	ED	
DIVISION OF OR ATTENDING PHYS DIRECTOR: After this of hours after death with Item 28 is marked.	ED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY building, etc. (Specify	— At home, farm, at		YES 2 NO	281. LOCATION (Stree City or Town, Stet	t end Number or i	Rural Route	Number,
	MPLET		CIAN: To the best of my knowled							
TO THE HOSPITAL TO THE FUNERAL BE filed within 72 IMPORTANT: II	BE CO	29b. SISMATURE AND TITLE OF GERTIFIER	t: On the basis of exemination of	end/or investigation	i, in my opinion, d	29c. LICENSE NUM	BER		IGNED (Mg/	nth, Day, Year)
263	2	30. NAME AND ADDRESS OF PERSON WHO				# 100	Laurel	1 4/	301	95
10		31. DATE (10.2 1995 J	A STANSON SON	Park I	C. Dr.	11/1/2	Caurel	17010	20-	70 7



**BALTIMORE, MARYLAND 21215-0020** DIVISION OF VITAL RECORDS, P.O. BOX 68769

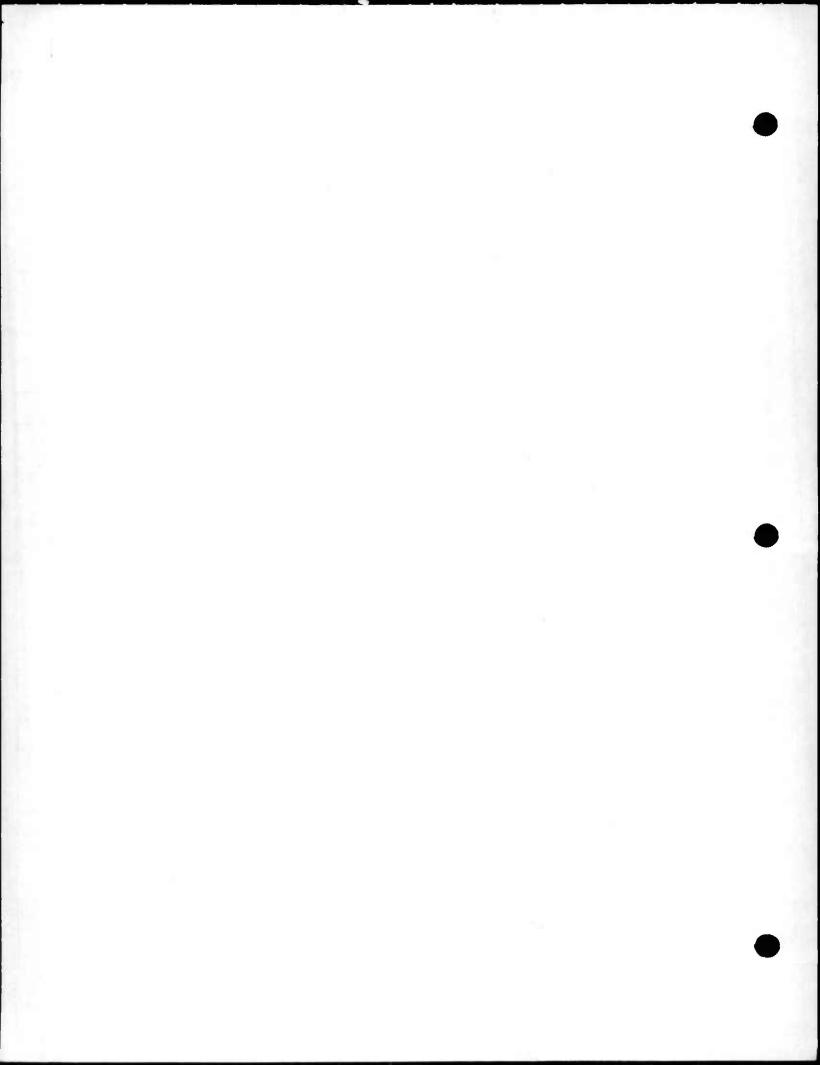
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 54 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle	le, Lest)							2. DATE OF DEAT		1	3. TIME OF DEATN	
	Kathr	yn J.	Wellf	ord					Apri	20	1995	6:35 Pm	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I		IF UNDER	DAYS	IF UNDER	R 24 HRS.	7 DATE OF BUTTH		8. BIRTHE	LACE (State or Foreign	
	212-24-4720	1 🗆 M 2 💢 F	79	YRS.					AUG. 24,	1915	MARY	LAND	
<u>~</u>	80. FACILITY NAME (If not institution				96. CITY, TOWN OR LOCATION OF DEATN  LAUREL						PRINCE GEORGE		
16	LAUREL REGIONA					Lf	TUKEL			PK	INCE	JEUKGE	
DIRECTOR		COUNTY	05.30.05	10c. CIT	Y, TOWN							10d. INSIDE CITY LIMITS?	
	MARYLAND  10a. STREET AND NUMBER	PRINCE	GEURGE			_	AUREL			1 40 . 01		1 YES 2   NO	
ERA	507 PRINCE GEO	DRGF STRFFT				10		707		10g. CI	USA	HAT COUNTRY?	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDE	NT EVER IN U.S. A	RMED	13.	WAS DEC	ENDENT O	OF NISPANI	IC ORIGIN? (Specify	Yes or No-		- Americen Indien, White, etc.	
BY	1 Never Married 2 Merrie 3 Widowed 4 Divorced	IF YES, GIVE	WAR OR DATES	, and				Specify:	, Puerto Rican, etc.			WHITE	
TEC	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do Not use retired)  16b. KIND OF BUSINESS/INDUSTRY												
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)  12  College (1-4 or 5+)  ADMINISTRATIVE ASSISTANT CITY GOVERNMENT									r			
CO	17. FATNER'S NAME (First, Middle, Last)  18. MOTNER'S NAME (First, Middle, Maiden Surneme)												
BE	CHARLES C. KASTNER  SUSAN K. McDONAL  190. INFORMANT'S NAME (Type/Print)  190. MAILING ADDRESS (Street and Number of Build Route Number City or Faul Street.)												
10	SUSAN K. POE 203 10TH STREET, LAUREL, MARYLAND 20707												
	20e, METNOD OF DISPOSITION  1 D Burlel 2 Cremetion 3 Removel from State  20b. PLACE AND DATE OF DISPOSITION (Name of completely cremetably of other (Specify) LAUREL, MARY LAND												
-	21. SIGNATURE OF FUNERAL SER	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	7	IIILL	22.	NAME A	ND ADDRE	SS OF FAC	HLITY FLECK	FUNE	RAL HO	OME. INC.	
	· / Cal	allando	coller									MD 20707	
- 0	23. PART I. Enter the disease shock, or heart f	es, or complications the allura. List only one ce	to on eath line	eath. Do	not enter	the mo	de of dy	ing, such	as cardiec or re	spiratory s	rrest,	Approximata	
	IMMEDIATE CAUSE (Final disesse or condition		7		) 0 1	0						Intervel Between Onset and Daath	
	resulting in death)	a. Due yo	OR AS A CONSI	C/	12/							DAYS	
z		- h	(on AD A CONS	LOOENGE O	r).								
NT I	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSE	OUENCE O	F):								
FIC.	cause. Enter UNDERLYING CAUSE (Disesse or injury that initieted evente	c	(OR AS A CONSE	OUENCE O	FI:								
CERTIFICATION	resulting in death) LAST	d			,								
	PART II. Other significent co	nditions contributing to	death but not	resulting	In the un	derlying	Couse (	given in F	Part I. 24e. WAS	AN AUTOPSY	24b. V	WERE AUTOPSY FINDINGS	
MEDICAL		Rempae	RALVA	BOUL	AR	1)	150	486		2 (NO		NAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
ME		DEMENT	MA									YES 2 NO	
AN	DID TOBACCO USE C 25. WAS CASE REFERRED TO MED						UNC	ERTAIN					
SICI	EXAMINER?	HOSPITAL:		CE DF DEA	OTHER	₹:		-2-5-00			- 15		
PHYSICIAN:	27. MANNER OF DEATN	28e. DATE OF	INJURY	28b. TIM	E OF	28c. INJ	URY AT		28d. DESCRIBE HO	W INJURY O	CCURED		
ВУ	1 Natural 5 Pendin 2 Accident Investi		Any, Tear)	IN.	M		RK? (E\$ 2 [	NO					
<u>a</u>	3 Suicide 8 Could 4 Homicide determ	not be building.	OF INJURY — At h	ome, term,	street, tect	ory, office			281. LOCATION (Sin City or Town, St	et end Numbe ete)	er or Rural Ro	ute Number,	
PLE	290. CERTIFIER 1 CERTIFYING	PNYSICIAN: To the best of	my knowledge, d	eath occurr	ed et the ti	ime, date	end plece.	end due t	o the ceuse(s) and	nenner es et	eted		
COMPLET		XAMINER: On the besie of a										end manner ee eteted.	
BE	296. SIGNATURE AND TITUE OF CE	ERTIFIER A	m	)			29c. LICE	ENSE NUME	BER 901	29d. DA	TE SIGNED (I	Month, Gay, Year)	
임	30. NAME AND ADDRESS OF PERS	ON WHO COMPLETED CAU					2		171		. ^	2	
	AUIS  31. DATE FILED (Month, Day, Year)	A - CASA	5 Mi)	83	17 0	che	KRY	LAN	VE LAL	KEC	un).	20707	
	MAY 0 2 1995	Jalia diludia	rivid										



DIVISION OF VITAL RECORDS, P.O. BOX 68760

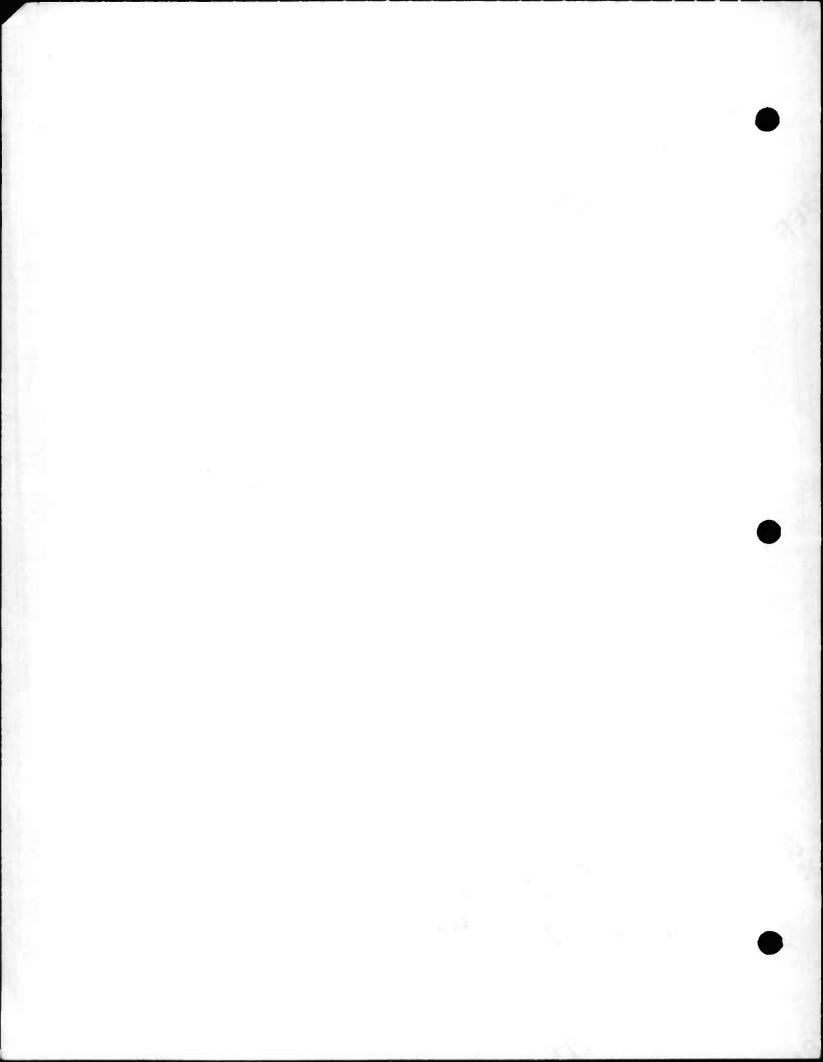
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit pe
be filed within 72 hours after death with the State Dept. of Realth and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

						95 13282
	1 - STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTMEN	NT OF HEALTH AND	MENTAL HYGIENE	•
	DECEOENT'S NAME (First, Middle, Last)	CAROLYN M.	WATTS		2. DATE OF DEATH DAY 04-27	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs.	last birthday) IF UND	ER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
	220-30-5450  9a. FACILITY NAME (If not institution, give st	1 □ M X X F 59	YRS. MONTH		08-27-3	5 MARYLAND
TOR	3802 OLD YOR		96. CI	BALTIMORE		9c. CGUNTY OF DEATH N/A
DIRECTOR	MARYLAND 10b. COUNTY	N/A	10c. CITY, TOWN	OR LOCATION  BALTIMORE	CITY	10d. INSIDE CITY LIMITS?  XXYES 2 \( \sqrt{1}\) NG
3AL	10e. STREET AND NUMBER	W 7017		101. ZIP CODE		10g. CITIZEN GF WHAT COUNTRY?
FUNERAL	3802 OLD YOR		ADMEO	2121		U.S.A.
B	1 Never Merried XX Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. FORCES? 1 Tyes 2X IF YES, GIVE WAR OR DATES	<b>X</b> 0	If yes, specify Cuban, Mexic  1 YES XXNO Spec	en, Puarto Rican, etc.)	or No— 14. RACE — American Indian, Black, White, etc. Specify: WHITE
TED	15. OECEDENT'S EDUC (Specify only highest grade	completed)	DECEDENT'S USUAL (Give kind of work don life. Do NOT use retired	e during most of working	16b. KIND OF BUSI	
COMPLET	Elementary/Secondary (0-12) 12 YEARS	College (1-4 or 5 +)	SECRE	,	HOSPI	TAL
	17. FATHER'S NAME (First, Middle, Last)  WILLIAM MAU	п.р			AME (First, Middle, Meiden S	
TO BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRE	SS (Street and Number or Rura	RED L.  Route Number, City or Town,	(UNK.)
ř	ALLAN T.WATTS	(HUSBAND)	3802 OL	D YORK ROA	D, BALTIMO	RE, MD., 21218
	20a METHOD OF DISPOSITION XX Burlel 2 Cremetion 3 Remo	oval from State 20b. PLAC	CEAND DATE OF DISP	CEMETERY		ATION — City or Town, State
	21. SIGNATURE OF FUNERAL SERVICE LICE	CENSEE		NAME AND AODRESS OF E	ACILITY	E ARUNDEL, MD. LTIMORE, MD. 21212
	R. M. Rus			HENRY W	. JENKINS	& SONS
	23. PART I. Enter the diseases, or c ahock, or heart fellure. I	complications that caused the List only one cause on each ii	death. Do not entent.	er the mode of dying, au	ch as cerdlec or reepire	atory arrest, Approximate Intervel Between
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Chrani	063	Coverin	Vulne	Onaat and Death
	readiting in death)	DUE TO (GR AS A CONS	SEOUENCE OF):	A	- Bray	any .
NO NO	Sequentially liet conditions, if any, leading to immediate	b. JULIALE DUE TO (OR AS A CONS	EEGUENCE OFI:	Huntie	- Bring	alule
RTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury	2 Styling a	other	alicus		
RTIF	that initiated eventa resulting in death) LAST	DUE TO (OR AS A CONS	BEĞUENCE OF):			
S	PART II. Other eignificent conditions	s contributing to death but so	A			
EDICAL	3311311311	e countries for death put the	t readiting in the i	inderlying cause given in	PERFGRM	MEO? AMAILABLE PRIOR TO
MED					1 YES X	OF DEATH?
	DID TOBACCO USE CONTR				KXKN	
SICIAN:	EXAMINER?  XXVES 2 \( \text{NO} \)	HOSPITAL: 1   Inpatient 2   ER/Outpatient	ACE GF OEATH (Chec		& Cher /Speciful	
РНУ	27. MANNER OF DEATH  XIX Natural 5 Pending	26s. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY	28c. INJURY AT WORK?	26d. DESCRIBE HOW IN	JURY OCCUREO
ВУ	2 Accident Investigation	260. PLACE GF INJURY — At	home form street to	1 YES 2 NO	201 LOCATION (Comme	
COMPLETED	4 Homicide 6 Could not be	building, etc. (Specify)	mer and the street, to	eter y, without	City or Town, Stete)	d Number or Rural Route Number,
APLE	29a. CERTIFIER XX CERTIFYING PHYSIC One)	CIAN: To the best of my knowledge,	death occurred at the	time, date and place, end du	e to the ceuse(s) end mann	er se stated.
SO	2 MEOICAL EXAMINER	R: Gn the beels of examination and/o	or investigation, in my	opinion, death occured at the	time, data and place, and	due to the cause(s) and manner as stated.
Щ	SIGNATURE AND TITLE OF CENTIFIER	n the		29c. LICENSE NU	MBER	29d. OATE SIGNED (Month, Day, Year)
O B	men III	LANK SO-		1000	746	<b>▶</b> 04-28-95

29d. OATE SIGNED (Month, Dey, Year)

▶ 04-28-95 MINTZER M.D., 3009 EVERGREEN AVE, BALTIMORE, MARYLAND, 21206

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First Middle Lest) 2. DATE OF DEATH 3. TIME OF DEATH MONTH _ 2904 _ 1995 HARRY DOUGLAS WHISTLER 11;40a M 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In vrs. last birthday) IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign 705-09-2894 DAYS HOLIBS XX M 2 - F 98 10-14-1896 MARYLAND 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR COLLEGE MANOR, INC. LUTHERVILLE BALTIMORE Pages 1, 2, 3 RESIDENCE OF DECEDENT 10a. STATE 10h. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE LUTHERVILLE permit. 1 YES XIX NO FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 300 WEST SEMINARY AVENUE 21093 funeral director, page 5 should be detached for use as the burial-transit U.S.A. executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician 11 MADITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2X NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES XX NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY Specify: Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) B & O RAILROAD CHIEF YEARS CLERK 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) HARRY W. WHISTLER Ħ OLEITA HARWOOD BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code 2 H.WHISTLER BURCH (NEPHEW) 1201 DOVES COVE ROAD, TOWSON, MARYLAND, 21286 pe 20a. METHOD OF DISPOSITION
1 ☐ Burlat XIX Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must 4 Donation 5 Other (Specify) DARLINGTON CEMETERY 5 - 2DARLINGTON, MD. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF HENRY W. JENKINS R. A. 2 un 4905 YORK ROAD, BALTIMORE, MD. 21212 the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiretory arrest, shock, or heart failure. List only one cause on each line. filled in by Interval Batwean **IMMEDIATE CAUSE (Final** Onset and Death the disease or condition_ arrhithma Ventricular completely event, t moment reaulting in death) burial, traumatic CERTIFICATION and Sequentially list conditions, prior to t DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Entar UNDERLYING other t CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS signed by the AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? ашу 1 TES 2 NO 1 TES 2 NO certificate has been DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) OTHER:
4 Nursing Home 5 Realdence 8 Other (Specify) t YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 許 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? s marked, 28d, DESCRIBE HOW INJURY OCCURED with . 5 Pending 1 YES 2 NO BY 2 Coldent Investigation ATTENDING 3 Suicide DIRECTOR: At hours after de Item 28 is r 28e. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined 4 Homicide COMPLET 8 29a. CERTIFIER (Check only one) 1) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. FUNERAL within 72 h TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 27 90 newmen 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

10755 FALLS RD. LUTHERVILLE, MD.

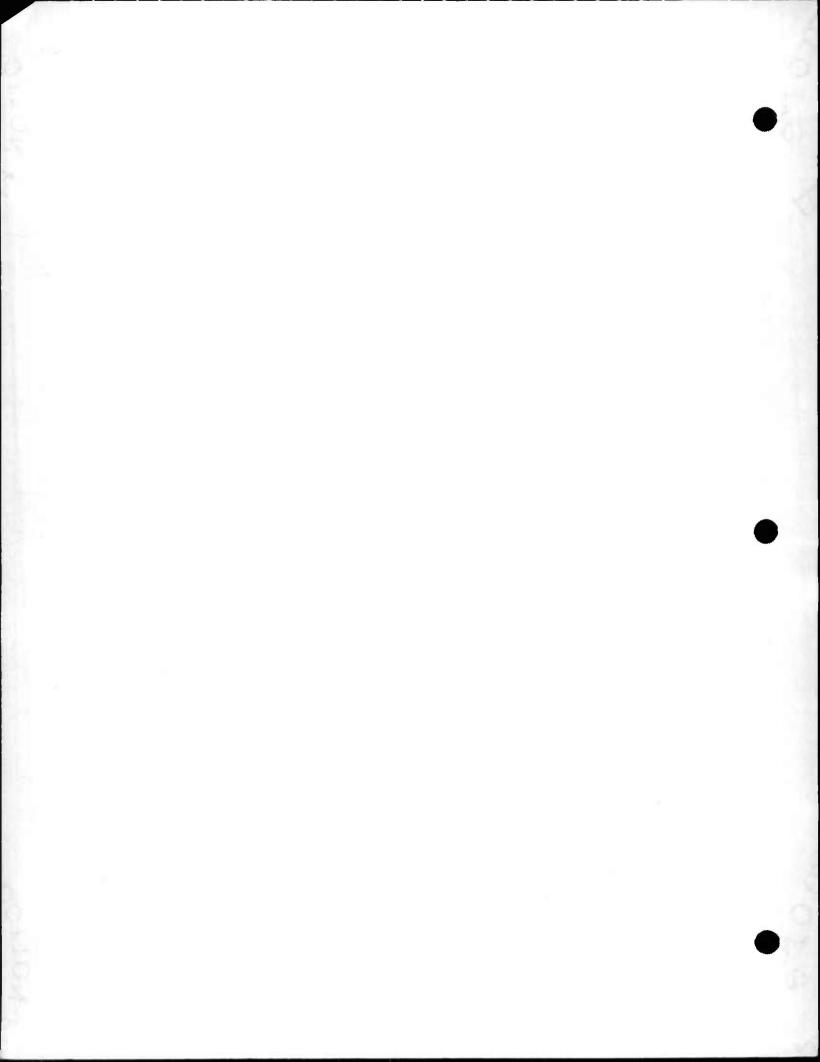
NEWMAN M.D.

RESTRAR SEIGNATURE

MARY M.

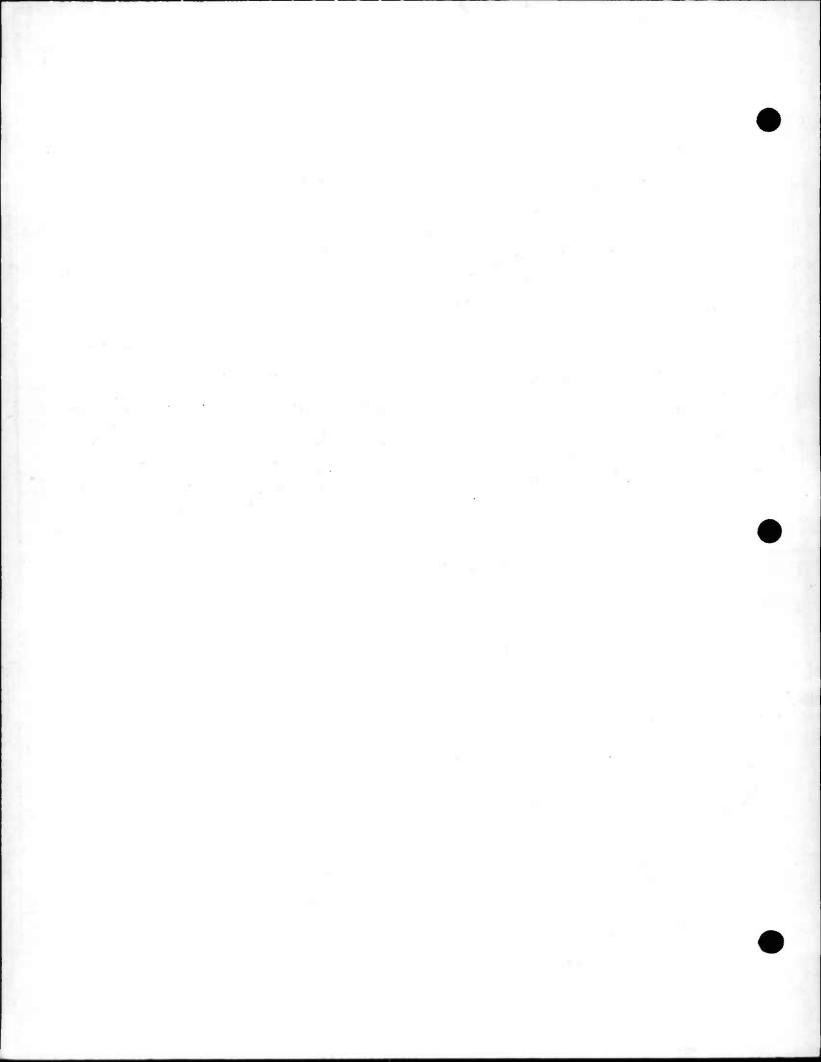
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BALTIMORE, MARYLAND 21215-0020	ed hours after death. Page 6 may be retained by the hospital or attending physic	filled in by the funeral director, page 5 should be detached for use as the burial ion or removal	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDED PRESIDENT THE LINE REQUISES THAT THE death certificate be executed within EA hours after death. Page 6 may be retained by the hospital or attending physicia	TO THE FUNERAL DIRECTOR After the continuous has been signed by the attenting physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transfer be filed within 72 hours.	
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		1 - STATE REGISTRAR	STATE OF M		D / DEPAR Certif						HYGIEN REG. NO.	E		
		1. DECEDENT'S NAME (First, Middle, Last) John Herbert								2. DATE OF MONTH	DEATH	7,199	YEAR	2:10p M
		4. SOCIAL SECURITY NUMBER 214-16-7271	5. SEX 1 1 M 2 F	8. AGE (In yrs	s. lest birthday) 4 YRS.	IF UNDER	t YEAR	IF UNDER	24 HRS. MIN.	7. DATE OF Month, D	BIRTH		8. BIRTHPL	ACE (State or Foreign ryland
OR.	5	9a. FACILITY NAME (If not institution, give street and number)  Meridian Nursing Spa Creek  Annapolis									9c. COUNTY OF DEATH Anne Arundel			
DIBECTOR	ineo.	RESIDENCE OF DECEDENT  10a. STATE MD  10b. COUNT Anne	NTY Arundel   10c. CITY, TOWN OR LOCATION   1							0d, INSIDE CITY LIMITS?				
	- 1	10e. STREET AND NUMBER 227 Candlelight Lane 21.061								AT COUNTRY?				
RY FIINFRAI		11. MARITAL STATUS  1 Never Married 25 Merried  3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  13. WAS DECENDENT OF HISPANIC ORIGINAL PROPERTY OF HISPANIC ORIGINAL PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF					, Puerto Rica	USA RIGIN? (Specify Yes or No— Id. RACE— Black, Specify Specify			- American Indian, White, etc.		
		(Specify only highest grad	CATION	-)	DECEDENT'S (Give kind of a life. Do NOT us	USUAL Of	CCUPATIO	N		16b. KI		SINESS/INOU		White
ed at once.  BE COMPLETED		17. FATHER'S NAME (First, Middle, Last) John Henry Wil	limas	14	aciiiii	150				ME (First, Mide	Marine Engineering  First, Middle, Maiden Surname)  Baugh			
		19a. INFORMANT'S NAME (Type/Print) Bertha Summers	Willima	as	19b. MAILING 227					ane,				e,MD 2106
must be		20e. METHOD OF DISPOSITION 1 G-Burlel 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donetion 5 ☐ Other (Specify)		20b.PLA cometery Hil	CEANDDATE ( Cremetory or of 1 Cres	ther plece)	ition(Ner			5/1		cation – conapol		
examiner	21. SEGNATURE OF PUNCHAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A.								D 21401					
ent, the medica										Interval Between Onaet and Death				
ry, or other traumatic event, the medical		Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events  Arterio-sclerosis  OUE TO (OR AS A CONSEQUENCE OF):  Due TO (OR AS A CONSEQUENCE OF):												
CER C		reaulting in death) LAST	d											
PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTO-PERFORMED						MED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?							
PHYSICIAN: MED		DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CA		EATH YE			UNC	ERTAIN	-   Jal				YES 2 NO
IYSICI/		EXAMINER?  1 YES 2 NO	HOSPITAL:		_		ing Home		aldenca 8	Other (S	pecify)			
D Hd		27. MANNER OF OEATH  1 Netural 5 Pending 2 Accident Investigation	28a. OATE OF (Month, D	ay, Year)		M		IRY AT RK? ES 2 [		26d. DEŞCR	IBE HOW IN	NJURY OCCU	IRED	
		3 Suicida 8 Could not be 4 Homicide detarmined	28a. PLACE O building,	F INJURY — A atc. (Specify)	t home, lerm, a	itreet, Jacto	ory, offica			281. LOCATIO City or T	ON (Street a own, State)	nd Number of	r Rural Rout	te Number,
BE COMPLE		29a. CERTIFIER (Check only 2 MEDICAL EXAMINI	ER: On the basis of a											nd manner as stated.
TO BE		296. THAT TITLE OF CENTIFIE	le	h	en	1		D 1	165	3		29d. DATE	8 / 9 5	onth, Day, Year)
		20. NAME AND ADDRESS OF PERSON WE Peter Verkous	, MD 1833	Fore	et Di		, A	nnaj	poli	s, M	D 21	401		
		MAY U 2 1995	- discussion	PUR SERVICE	E									

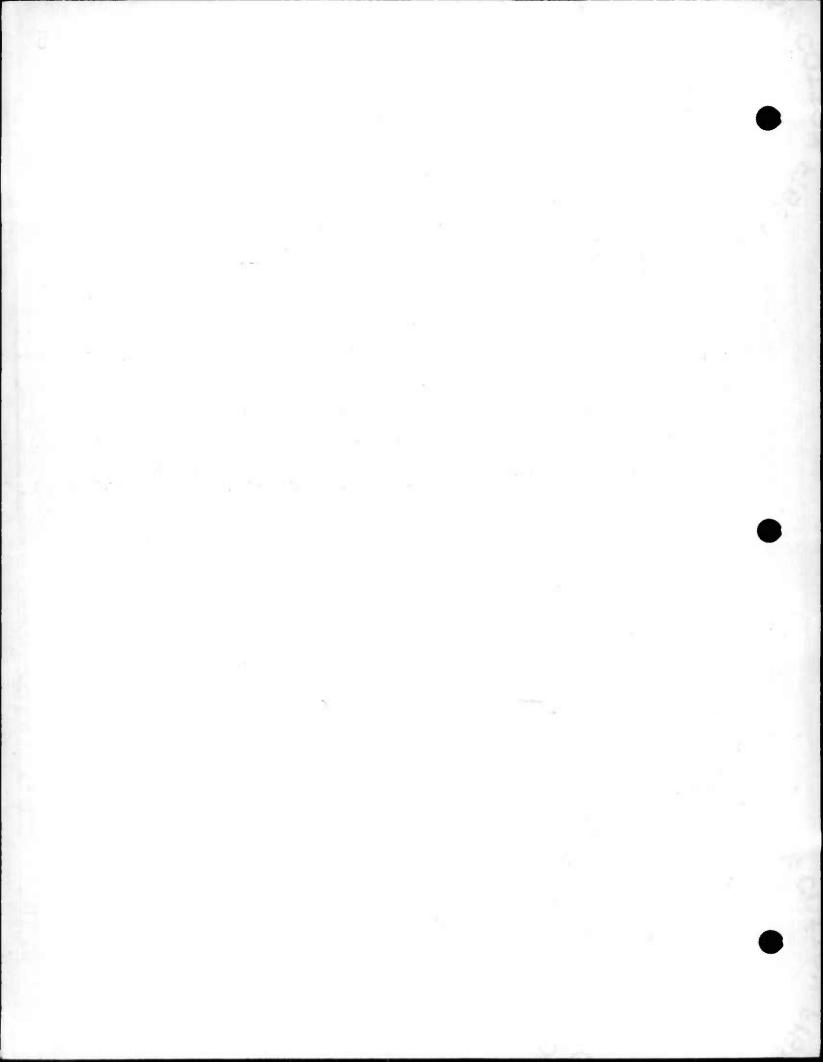


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DIVISION OF VITAL RECORDS, P.O. BOX 68760

al or attending physician.	for use as the burial-transit permit. Pages 1, 2, 3 should
24 hours after death. Page 6 may be retained by the hosp	filled in by the funeral director, page 5 should be detached on, or removal.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a	TO THE FUNERAL DIFFERM AND THE MIS CENTIFICATE has been signed by the attending physician and completely be filed within 72 years after the little State Dept. of Health and Mental Hygiene prior to burial, crematic

								9	) 13203	
	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMENT OF	HEALTH AND	MENTAL	HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)  MARION	ZERWITZ					IL 27	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 212-03-9208	5. SEX 6. AGE	(In yrs. lest birthdey)  6 YRS.	IF UNDER 1 YEAR		7. DATE C		8.	BIRTNPLACE (State or Foreign Country) MARYLAND	
СТОВ	99. FACILITY NAME (If not institution, give stress 3304 MARNAT ROA	C-1-2-00/2			ALTIMORE	DEATN		9c. COUNTY	OF DEATH	
[	RESIDENCE OF DECEDENT  10e. STATE 10b. COUNTY		10c. Cf	TY, TOWN OR LO	CATION				10d. INSIDE CITY	
L DIRE	MARYLAND  104. STREET AND NUMBER	BALTIMO			ALTIMORE 101. ZIP CODE			Las OUTITE	1 TYES 2 X NO	
FUNERAL	3304 MARNAT ROA	D			21208			USA		
I	11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS	DECENDENT OF HISPA		(Specify Yes			
₩	1 Never Married 2 Merried 3 X Widowed 4 Divorced	FORCES? 1 TYES	ATES NO	If yes,	specify Cuben, Mexic 'ES 2 ∰ NO Spec	Black, White, etc. Specify WHITE				
LETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed)  College (1-4 or 5+)	16e. DECEDENT'S (Give kind of life. Do NOT u	work done during	ATION most of working	16b.	KIND OF BU	SINESS/INDUS		
once. COMPL	12 17. FATHER'S NAME (First, Middle, Last)		ASSI	STANT I					ESTATE	
m m	IDEL  19s. INFORMANT'S NAME (Type/Print)	НОСН			18. MOTHER'S N	IE		RAI	PPOPORT	
TO BI	MR. FRED ZERWITZ		1		et and Number or Rura					
examiner must be	20e. METHOD OF DISPOSITION  1 Name   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year   Year	val Irom State 20th	p. PLACE AND DATE netery, crematory or SHAARE]	of Disposition		DATE			or Town, State	
Je	21. SIGNATURE OF FUNERAL SERVICE LICE	Nee	SHAARE		AND ADDRESS OF F	4-28-	1995	BALT	TIMORE, MD	
xami	Jack 1	y Low	1.1		LEVINSO				IMORE, MD 2121	
event, the medical	23. PARI I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or reapiratory arrest, approximate interval Between Onset and Death Onset and Death  DUE TO (OR AS A CONSEQUENCE OF):									
ry, or other traumatic	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):									
shows any injury, : MEDICAL C	PERFORMED?  1 VES 2 NO COMPLETI DF DEATH							24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?		
	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	F DEATH Y	ES 🗆 NO	M UNCERTA	IN []			1 TYES 2 NO	
ed, or item 23 s PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEA	TH (Check only o	/ 1					
YSI	1 🗆 YES 2 NO	1 Inpetient 2 ER/Outp	petient 3 DOA	OTHER: 4  Nursing H	ome 5 Residence	6 🗆 Other	(Specify)			
med,	27. MANNER OF DEATH  1 Netural 5 Pending	26e. DATE OF INJURY (Month, Day, Year)	26b. TIN	JURY	NJURY AT WORK?	26d. DESC	RIBE NOW II	NJURY OCCUR	ED	
2 Accident Investigation							and Number or Rural Route Number,			
		AN: To the best of my know								
MPORTANT: II	29b. SIGNATURE AND TITLE OF CERTIFIER	On the basis of examination	n end/or investigation	on, in my opinior	, death occured at the 29c. LICENSE NU		nd place, an		gneo(s) end menner ee stated.  GNEO (Month, Day, Year)	
TO B	(And)				03317	7		D 4/1	8/85	
	DR. AARON GOLDBER	G 6804 PARK	HEIGHTS		BALTIMORE	, MD 2	1215			
	31. DATE FILED (Month, Day, Ybar)  2 1995	32 REGISTRAR SIGN	<b>点线</b>							



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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF CEATH 3. TIME OF DEATH April 1995 Р. м 5:55 Olive Andrews Eleanor 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 🗌 M 2 🔀 F 214-01-6015 October 10,1905 89 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9h. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Mefbridge Medical & Physical Rehab Rossville Baltimore 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore Baltimore 1 TYES 2 X NO Maryland permit. FUNERAL 10g, CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit Kenlea 21236 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No within 24 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 🔨 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Maxican, Puerto Ri

1 YES 2 X NO Specify: 1 Never Married 2 Married Spec#y: White BY 3 X Widowed 4 Divorced COMPLETED 15. DECEOENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) Goldseker Realty Co. 10 Real Estate Agent 17. FATHER'S NAME (First, Middle, Last) 18, MOTHER'S NAME (First, Middle, Maiden Surname) notified at Janco Wilma BE John Mikucki 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Kohler Same as 10e Andrew pe 20a. METHOD OF DISPOSITION 20b. PLACE AND OATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must 1 N Buriel 2 Cremation 3 Ramoval from State
4 Donation 5 Other (Specify) orraine Park Cemetery 5/4/95 Baltimore, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF Leonard J. Ruck Funeral Home . U or old 5305 Harford Rd. Balto. Md. 21214 the event, the medical 23. PART i. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. ind completely filled in by i Approximate interval Between cremation, or IMMEDIATE CAUSE (Finel Onset and Death disesse or condition resulting in desth) DUE TO (OR ASA CONSEQUENCE OF): SCVC or other traumatic 10 CERTIFICATION and Sequentially list conditions, 2 DUE TO (OR AS A CONSEQUENCE OF) if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST Mental PART ii. Other significant conditions contributing to desth but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS signed by the AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any 1 - YES 2 NO 1)e live Jan Juseune 1 | YES 2 | NO 6 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D PHYSICIAN: 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h with the State [ EXAMINER? HOSPITAL: OR ATTENDING PHYSICIAN: ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA ursing Home 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural M 1 YES 2 NO ΒY death 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office 90 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be DIRECTOR: after item 28 4 Homicide hours 29a. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE FUNERAL I be filed within 72 h IMPORTANT: If II (Check only one) THE HOSPITAL 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE BIGNED (Month, Day, Year) 2 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)

9618 Belair Road - 21236

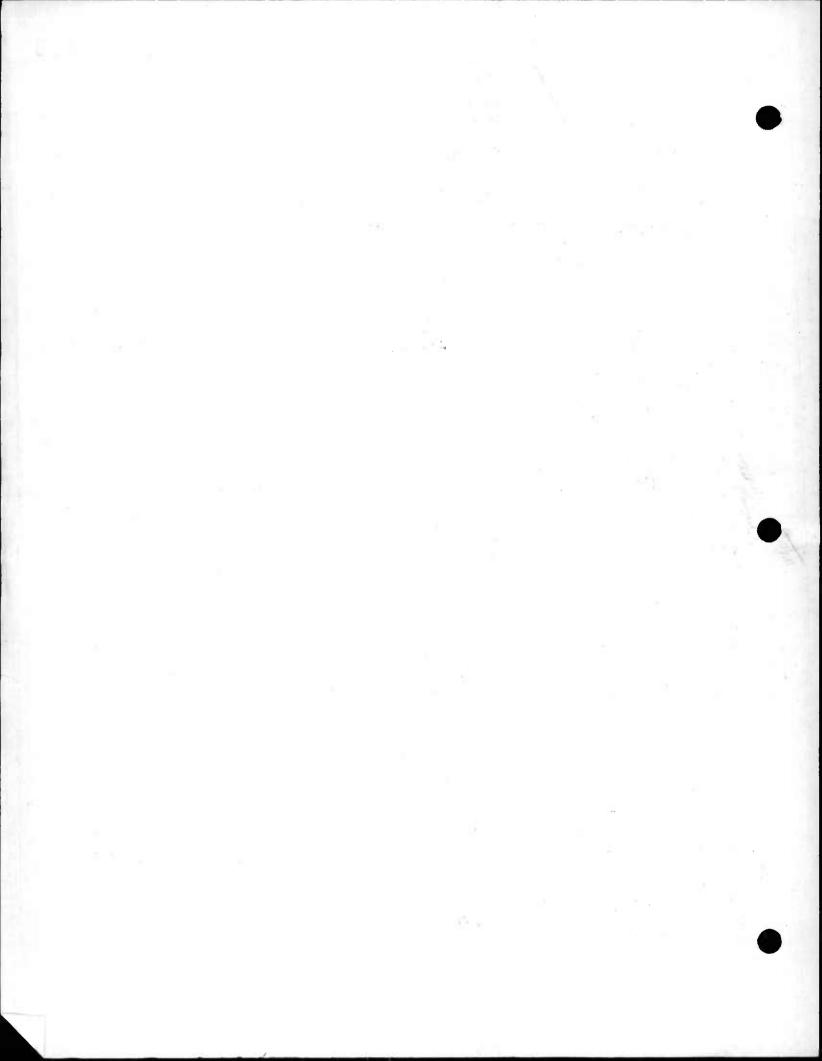
324 REGISTRAR'S AGNATURE

Howard H

31. DATE FILED (Month, Day, Year)

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI			) MENTA	AL HYGIEN REG. NO	_		1 47 6.00	
	1. DECEDENT'S NAME (First, Middle Last)	Bern	steel			2. DAT	E OF DEATH	AY	YEAR	3. TIME OF DE	ATH
- 3	Lonald 1		11/0	14 2	1:36	4+ "					
	4. SOCIAL SECURITY NUMBER		MC	UNDER 1 YEAR	IF UNDER 24 HRS	(Mon	E OF BIRTH hth, Day, Year)		8. BIRTH Country	IPLACE (State or ry)	Foreign
	175-24-6995  9o. FACILITY NAME (If not institution, give str	1 XM 2 F	04	CITY TOWN C	R LOCATION OF		st 4, 1			nnsylva	nia
Œ.	University Hospi	1.000	9			DEATH		9c. COU	NTY OF D	DEATH	
5	RESIDENCE OF DECEDENT	ruai		Baltim			-		N/A		
DIRECTOR	10e. STATE 10b. COUNTY			OWH OR LOCAT						10d, INSIDE C	TY
	Md. Wo	orcester	Bish	nopvill	ZIP CODE			I too CITI	ZEN OF V	1 TYES 2X	./\
FUNERAL	11201 St. Martir	is Neck Rd			21813			log. om	US		
S	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC	ENDENT OF HIS	PANIC ORIGI	IN? (Specify Yes	or No-	14. RACI	E — American In	dian,
ВУ Б	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	TES NO		2 NO Sp		Rican, etc.)		Spec		
	15. DECEDENT'S EDUC	ATION	16a. DECEDENT'S US	UAL OCCUPATION	IN .	16	b. KIND OF BUS	SINESSINO	HETDY	white	
ETE	(Specify only highest grade of Elementary/Secondery (0-12)	College (1-4 or 5+)	(Give kind of world life. Do NOT use n	done during mo	st of working	1.0	o. KIND OF BO.	JINE 33/IND	OSINI		
MPL	12	N/A	Shippin	g Fore	man	P	hoenix	Stee	el Co	orp.	_
COMPLETED	17, FATHER'S NAME (First, Middle, Last)				18. MOTHER'S		Middle, Maiden				
BE	Dawson Bernsteel	L, Sr.			May E						
2	190. INFORMANT'S NAME (Typo/Print)  ROSS Gaglio		19b. MAILING AC								1010
	20g. METHOD OF DISPOSITION	20b.	11201 S					CATION —			1813
- 1	1 X Burial 2 Cremetjon 3 Ramon 4 Donation 5 Other (Specify)	val from State ceme	etery, crematory or other	eterv		5/				e, Pa.	
- 1	21. SIGNATURE OF EUNERAL SERVICE LICE			22. NAME AN	D ADDRESS OF	FACILITY					
	1 Vary	7. Loufo	non		. Kauin ain St.					Elk., I	nc.
	23. PART I. Enter the diseases, or co ahock, or heart (gliure, L	int only pre cause on a	the death. Dp npt	enter tha mo	da of dying, s	uch aa ca	rdiac Dr reapi	ratory arr	est,	Approxi	
	IMMEDIATE CAUSE (Final	\ 1									Betwean nd Daath
	disease or condition and potension								nr		
_	TOTAL DE LE LA CONSCIUENCE OF):									-	
5	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):	COOL	inge					21	
S	cause, Entar UNDERLYING CAUSE (Disease or injury	aortoer	Heric	tis-	tula					30	Days
E	that initiated eventa	DUE TO (OR AS A	CONSEQUENCE OF):	+10	<b>A</b> -	14				20	,
CERTIFICATION	d.	infecto	aor	MC	gra	DT				20	yrs
	PART II. Other aignificant conditions	contributing to death be	at not reaulting in t	he undarlying	cause givan	in Part I.	24a. WAS AN		24b	WERE AUTOPSY AVAILABLE PRICE	
8							1 TYES 2	NO		COMPLETION O	
ME										1 - YES 2	NO
AN	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL		F DEATH YES		UNCERTA	AIN 🗆	<u></u>				<u>`</u>
PHYSICIAN: MEDICAL	EN ANNUESO	HOSPITAL:	0	THER:	5 🗆 Resident		es /Spenikul				
Ή	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	F 28c. INJ	JRY AT	_	SCRIBE HOW II	NJURY OCC	URED		
BY	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Tear)	INSON		RK? ES 2 NO						
	3 Suicide 8 Could not be 4 Homicide determined	28a, PLACE OF INJURY building, atc. (Speci	At home, term, atre-	et, factory, office			CATION (Street e or Town, State)	and Number	or Rural F	Route Number,	
<u> </u>	4										
COMPLETED		NAM: To the best of my knowle									
8		t: On the beals of exeminetion	and/or investigation, i	n my opinion, d			a and placa, an				
H	1990 SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE	10L	[	29d. DATE	SIGNED	(Month, Day, You	r)
임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, Pri	nt)	PUT	477		, )	1-	75	
	TRACY A. MA	GNUSON	mo 2	2 5.	The	en	57.			2/2	Q/
	MAY 0 3 1995	Modertan	A.								

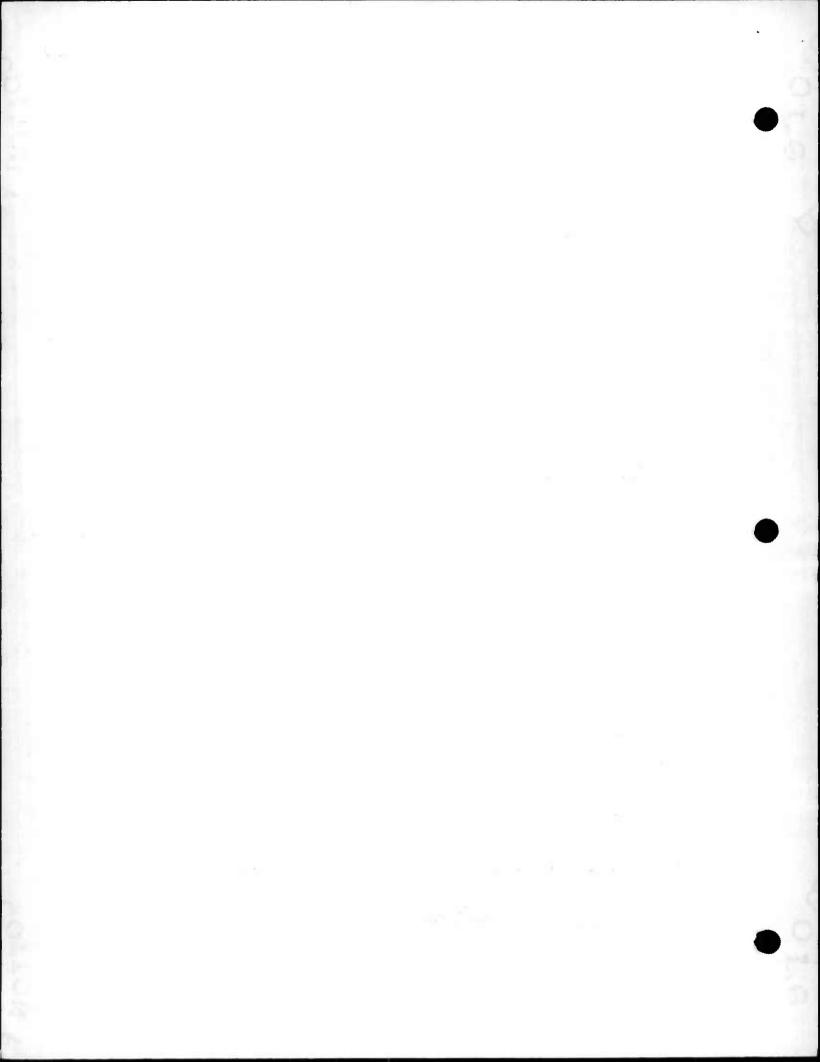
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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle Last) 2. DATE OF DEATN 3. TIME OF DEATH XEAR 45 2A ADSI MARY VERA BEVANS 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR 8. BIRTNPLACE (State or Foreign 1 M 2 X XF DAYS HOURS 218-34-0667 June 10,1916 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Stella Maris Hospice Baltimore Towson RESIDENCE OF DECEDENT 10h COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Middle River permit. 1 TES 2 NO 10a. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? retained by the hospital or attending physician. 5 should be detached for use as the burial-transit 21220 USA 10205 Beyons Lane 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES XXXVO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—II yea, specify Cuban, Maxicen, Puatio Rican, etc.)

1 YESXX NO Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married * Married BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16a. OECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 7 yrs. N/A Housewife Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Lemuel Piercy Nellie Hobbs 8 notified funeral director, page 5 should 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Charles C. Bevans 10205 Bevans Lane Baltimore. Maryland 21220 Page 6 may be è 20a METHOD OF DISPOSITION

(A) Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION -- City or Town, State must Holly Hill Mausoleum 5-1-95 4 Donation 5 Other (Specify) Baltimore, Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY death. · Welliam E. F. Lassahn Funeral Home Gack 11750 Belair Rd. Kingsville, Md. the 21087 medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. Liet only one cause on each line. filled in by Approximata interval Between IMMEDIATE CAUSE (Finel Onset end Death Canses of Bladdon disease or condition_ and completely fi o burial, cremation Cell month event. resulting in death) traumatic CERTIFICATION Sequentially list conditions, prior to t DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): thet initieted events resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS signed by the AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATN? апу 1 TYES 2 NO shows 1 YES 2 NO been of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has by Dept. 1 PHYSICIAN: W. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) OR ATTENDING PHYSICIAN: The certificate h **EXAMINER?** HOSPITAL: 1 YES 2 NO OTHER:
4 | Nursing Home 5 | Residence | Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Hospice the 27. MANNER OF OEATH 28a. OATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d, OESCRIBE NOW INJURY OCCURED this c marked, Netural 2. Accident 5 Pending 1 YES 2 NO BY After Investigation 28a. PLACE OF INJURY — Al home, lerm, streel, lectory, office building, alc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is 8 Could not be determined DIRECTOR: / COMPLETED 4 Nomicide 29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the itme, data and place, and due to the cause(e) and manner as stated. HOSPITAL FUNERAL ( within 72 h 1 2 MEDICAL EXAMINER: On the basic of exemination end/or investigation, in my opinion, death occurred at the time, data end place, end due to the cause(a) end manner as stated. TO THE HOSPITA
TO THE FUNERA
be filed within 72
IMPORTANT: II 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. OATE SIONED (Month, Day, Year) Kendall R aukalus 195 2 30. NAME AND AODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204 32 PEGISTEAR'S CONTINUE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



Pages 1, 2, 3 should

permit.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attends	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as it he find within 72 hours after death with the State Debt, of Health and Mental Horiene Drior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The I	TO THE FUNERAL DIRECTOR: After this certificate has be filed within 22 hours after death with the State De	IMPORTANT: If Item 28 is marked, or item 2

Vivient

31. DATE FILED (Month, Day, Year)

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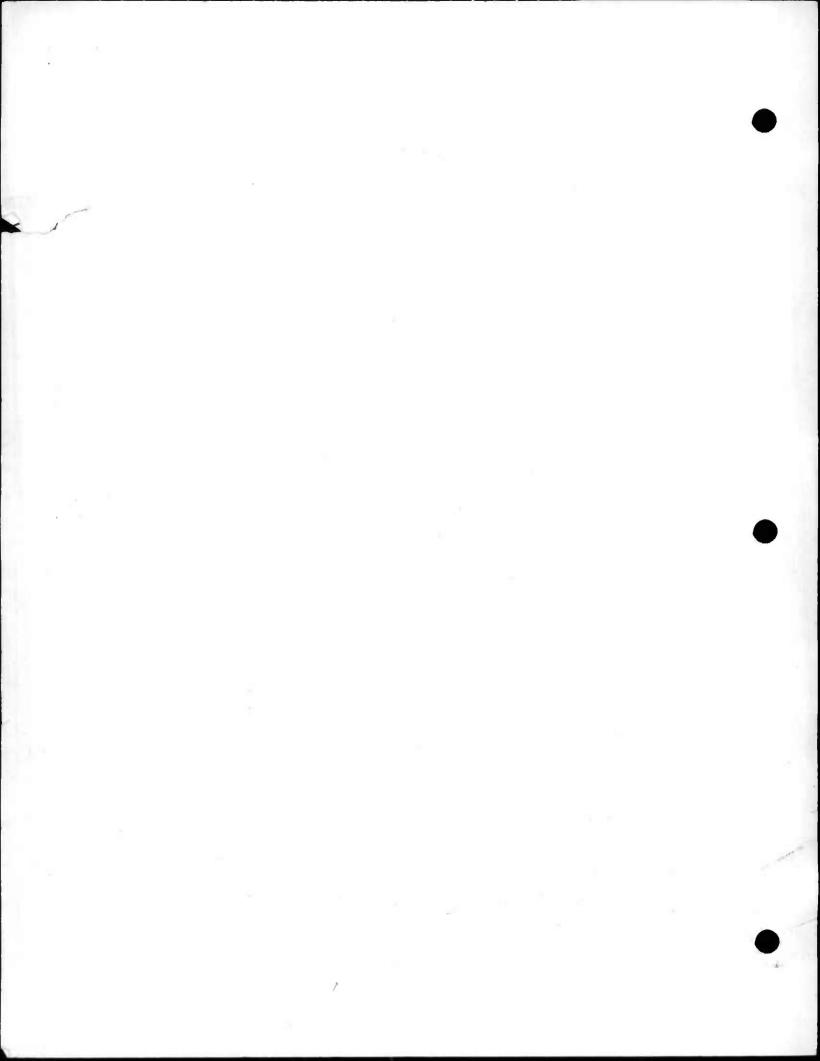
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32. REGISTRAR'S SIGNATURE Davolson Randall

Hospital

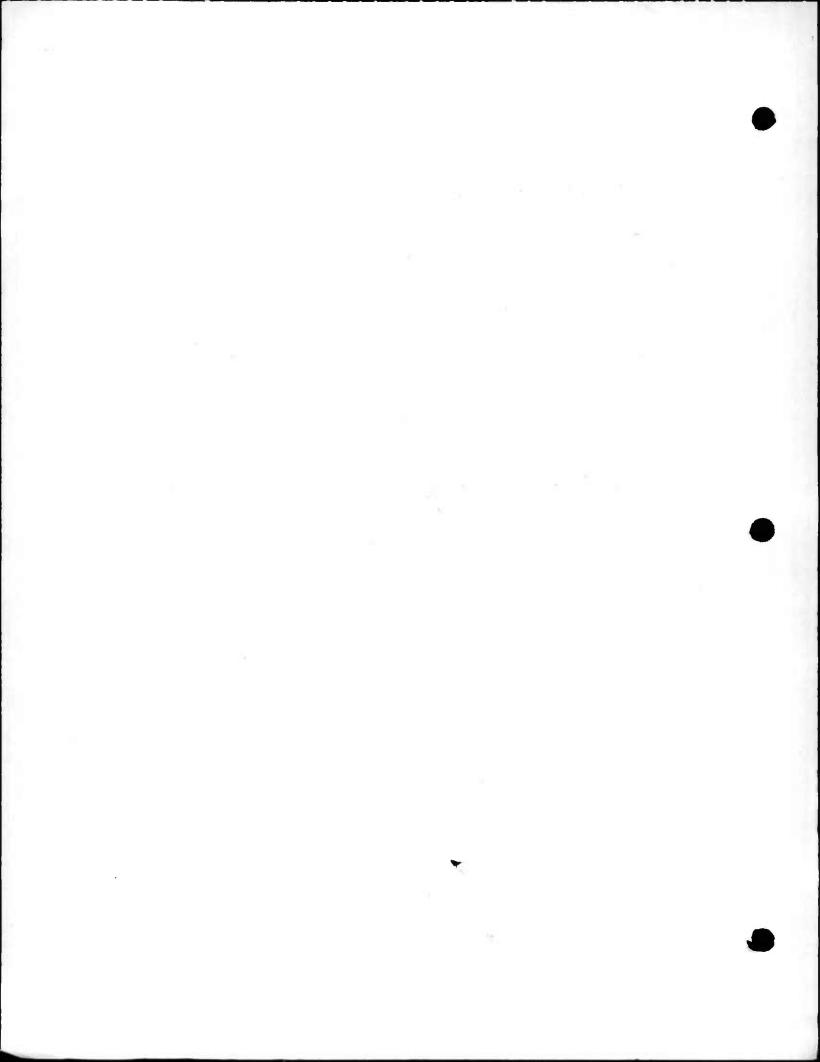
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR 2-00A art Anny 30 4. SOCIAL SECURITY NUMBER BIRTHPLACE (State or Foreign Country) 7. DATE OF BIRTH (Month, Day, Year) 5. SEX 8. AGE (In yrs. last birthday, IF UNDER 1 YEAR IF UNDER 24 HRS. Baltimus 8-Tiene 9a FACILITY NAME /// not institution 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN Bultimore DIRECTOR Baltimore (it 10b. COUNT 10c. CITY, TOWN OR LOCATION LIMING ST Baltimore City Maryland Baltimore 1X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP COOF 10g. CITIZEN OF WHAT COUNTRY? 2237 West Fayette Street 21223 U.S.A 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yee, specify Cuban, Maxicen, Puarlo Rican, etc.)

1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES X 1 Never Married 2 Merried Specify: Black В 3 Widowed 4 Divorced 16a. DECEOENT'S USUAL OCCUPATION
(Give kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY ive kind of work done Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 Retired Unknown 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) क्र John T. Barbour BE E11a Barbour notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2 Helen Roy 2237 West Favette Street Balto. MD 21223 è 20a. METHOD OF DISPOSITION
14 Burlal 2 Committee 3 D
4 Donation 5 Donat (Sport) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must Mount Auburn Cemetery 5/5/95 Balto. MD examiner 21. BIGNATURE OF FUNERAL BERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Estep Bros. Funeral Home P.A. 23. FART I, Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory medical Approximata ahock, or heart fallure List only one ceusa en each line interval Between IMMEDIATE CAUSE (Final **Onset and Death** 幸 mease or condition resulting in death) neumonia event. DUE TO (OR AS A CONSEQUENCE OF): m traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF) CAUSE (Disease or injury other that initieted events resulting in death) LAST 6 injury. PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? any 1 TYES 2 TO shows 1 TES 2 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) Item HOSPITAL: OTHER: 1 YES 2 NO Inpetiant 2 - ER/Outpetient 4 - Nursing Nome 5 - Residence 8 - Other (Specify) 0 28e. DATE OF INJURY (Month, Day, Year) 27, MANNER OF DEATH 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED marked. 1 Natural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 3 Suicide COMPLETED Could not be 28 4 Nomicide Item 29e. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the fime, date and piece, and due to the cause(e) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the beels of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner es stated. 29c. LICENSE NUMBER VL 9833 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) BE Mn 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)

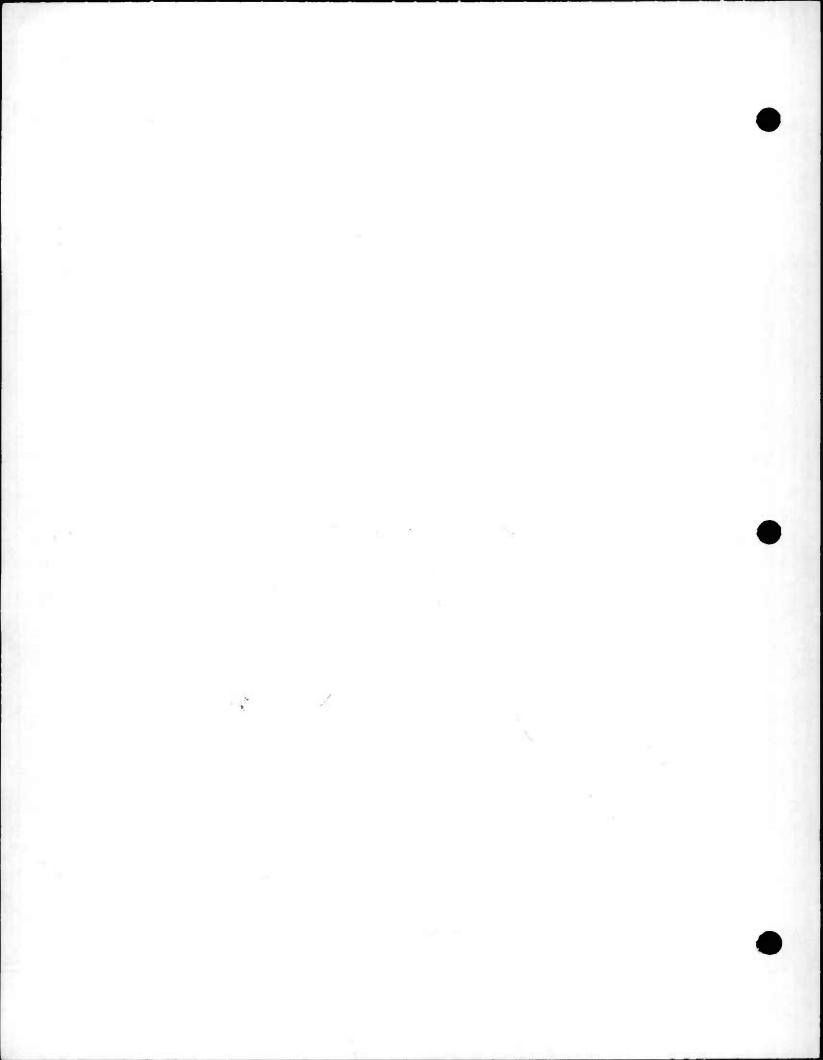


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		FOR 1 - STATE REGISTRAR			MENT OF HEALTH AT			
		1. DECEDENT'S NAME (First, Middle, Last)  ALFONZO	Bohann	الراجية المساء		2. DATE OF DEATH MONTH D April 2	AY YEAR	3. TIME OF DEATH
if. Pages 1, 2, 3 should		4. SOCIAL SECURITY NUMBER  245-18-3134  9a. FACILITY NAME (If not institution, give	5. SEX 6. AGE (	(In yrs. last birthday) III	UNDER 1 YEAR IF UNDER 24 H NTHS DAYS HOURS M D. CITY, TOWN OR LOCATION (	Jan 23, 1	Country	h Carolina
	TOR	Levindale Convale	scent Center	1	Baltimore Baltimore		n/a	
	DIRECTOR	10a. STATE 10b. COUNT Maryland	n/a		own on Location			10d. INSIDE CITY LIMITS? 1 TYPYES 2 NO
sit permit.	RAL	10e. STREET AND NUMBER			10f. ZIP CODE		10g. CITIZEN OF WI	
215-0020 attending physician. se as the burial-transit	BY FUNERAL	3610 Ferndale Ave  11. MARITAL STATUS  1 Never Married 2 K Married  3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 TYPES IF YES, GIVE WAR OR D. May 143 — De	2 NO ATES	13. WAS DECENDENT OF H If yes, specify Cuban, M 1  YES 2 No. 8	ISPANIC ORIGIN? (Specify Yellexican, Puerto Rican, etc.)	usa a or No— 14. RACE Black, Specify	
or afte	LETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION	18a. DECEDENT'S US	done during most of working	16b. KIND OF BU	SINESS/INDUSTRY	Bl.ack
the hospital detached fo	COMPL	9th Grade 17. FATHER'S NAME (First, Middle, Last)		Cha	uffer 18. MOTHER	Food Fa	ir, Inc.	
# 8 4 Z	BE	unknown  198. INFORMANT'S NAME (Type/Print)		10h MAH ING AD		known		
E, MAR y be retained sage 5 should be notified	임	Frances B. Bohann		3610 Fe	press (Street and Number of F rndale Avenu	e Baltimo	re, Maryl	
Page 6 may al director, pa		1 \( \times \text{Burlel} \) 2 \( \times \text{Cremation} \) 3 \( \times \text{Rem} \) 4 \( \times \text{Donation} \) 5 \( \times \text{Other} \( (Specify) \) 21. SIGNATURE \( \text{F} \) FUNERAL SERVICE LI	oval from State	PLACE AND DATE OF D Belery, cremetory or other D Veteran C	emetery/Garr	ison May 2 Ow	cation - city or tow rings Mil.1.	s. Marvlan
ALT death. e funera il.		2 ment to	Emy	W-	Baltimore,	Falls Parkw Maryland 21	216	omes, Inc
bu,  I within cours after mpletely filled in by the cremation, or removal event, the medical		23. PART i. Enter the diseases, or ahock, or heart feliure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)	Liet only one ceuse of e	ech iine.	enter the mode of dying,  o - pulmox  heart			Approximete interval Between Onset and Death
U.S., P.O. BOX 687, the death certificate be executed the attending physician and co 1 Mental Hygiene prior to burial injury, or other traumatic e	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. Sep 5	osclewh consequence of: is consequence of:		disease	,	
L RECORDS, F law requires that the death as been signed by the atte lept. of Health and Mental 23 shows any Injury, o	MEDICAL C	diabetes mall	e contributing to death b  Hypert  hus periphe	ut not resulting in t	ne underlying cause give bight Below three comp la discusse	PERFOR	RMED?	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
as been	PHYSICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL		F DEATH YES	Oheck only one)	TAIN 🗆		
CIAN: The strifficate the State or Item	YSIC	1 YES 2 NO	HOSPITAL:		FHER: ☐ Nursing Home 5 ☐ Reside	nca 8 Other (Specify)		
ATTENDING PHYSICIAN: The ATTENDING PHYSICIAN: The ECTOR: After this certificate his safter death with the State Dis marked, or Item	ву Рн	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. TIME O	M 1 YES 2 NO	28d. DEŞCRIBE HOW I	NJURY OCCURED	
OF ATTENDING DIRECTOR: After hours after death teem 28 is ma	8	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY building, atc. (Spec	— At home, farm, stree	t, factory, offica	28f. LOCATION (Street a City or Town, State)	and Number or Rural Ro	ute Number,
Z Z Z =	COMPLET		CIAN: To the best of my knowl R: On the besis of examination					and menner as stated,
TO THE FUNER TO THE FUNER DE filed within 7	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIE	Warez m		29c. LICENSE	NUMBER 14907	29d. DATE SIGNED (	Month, Day, Year) 27/95-
Ske		30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Typo, Prin	"w. Belvedi	en pre	2/2/5	
الله الم		MAY 03 1995	Se REGISTRAR'S SIGN	ATURE				



		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMENT OF I	HEALTH AND	MENTAL HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Last)  DORIS Ann Murra	Y BOWMAN				2. DATE OF DEATH MONTH	MY YEAR	3. TIME OF DEATH  6:55 A	
_		4. SOCIAL SECURITY NUMBER		In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8, Bit	RTHPLACE (State or Foreign untry)	
ages 1, 2, 3 should		218-46-5591 Sa. FACILITY NAME (If not institution, give s	1 DM 2 TF	46 YRS.	MONTHS DAYS	HOURS MIN.	June 22,	1948	Maryland	
	TOR	GREATER BALTIMO		ENTER	96. CITY, TOWN	OR LOCATION OF C	DEATH	9c. COUNTY O		
	DIRECTO	10a. STATE 10b. COUNT	Y	10c. Cf1	Y, TOWN OR LOCA	TION			10d. INSIDE CITY	
permit. Pages		Maryland n	/a		Baltimor	ce		LIMITS?		
	FUNERAL	1734 Moreland Ave	nuo		10	f. ZIP CODE		F WHAT COUNTRY?		
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit notified at once.	5	11. MARITAL STATUS	12. WAS OECEDENT EVER IN	U.S. ARMED	13. WAS DEC	21217 CENDENT OF HISPA	NIC ORIGIN? (Specify Ye	a or No- 14. R	ISA ACE — American Indian,	
	BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES IF YES, GIVE WAR OR DA		If yes, sp 1 — YES	S 2 NO Spec	an, Puarto Rican, etc.) //y:	В	eck, White, etc. pecify: Black	
	TED	15. OECEDENT'S EDU (Specify only highest grade	CATION completed)	(Give kind of	USUAL OCCUPATE work done during mo	ON ost of working	16b. KIND OF BU	ISINESS/INDUSTR		
	COMPLETED	Elementary/Secondary (0-12) 11th Grade	College (1-4 or 5+)	Ille. Do NOT u	se retired.)		D1 '- 1			
AND 2 the hospital detached fo	MO	17. FATHER'S NAME (First, Middle, Last)		Nurse	s Assist		EJ.1Zali AME (First, Middle, Maiden	oeth Coo	ney	
AYL d by th	BE C	Calvin C. Murray				Pearl.				
MAR retained to 5 should notified	10	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Tox			
		James Bowman	ans.		Moreland			ore, Mar		
ALTIMORE, Jeath. Page 6 may be funeral director, page xaminer must be		1 A Burlal 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	oval from State ceme	etery, crematory or o			May 2 Po 1	CATION — City or	County, MD	
ALTIMO death. Page 6 e funeral directo 1.	,	21. SIGNATURE OF FUNERAL SERVICE LI		Lacab II	22. NAME A	ND ADDRESS OF F			Homes, Inc	
0 = 0	,	Devr	tarker		2301	Gwynns i	Falls Parkwarvland 21	vay	,	
hours aft ed in by or remo			complications that caused List only one cause on ea	the death. Do nich line.	not enter the mo	ode of dying, au	ch ea cerdiac or reap	Iratory arreat,	Approximate interval Between	
tely fille mation,		iMMEDIATE CAUSE (Finel disease or condition resulting in death)	. Kespir	aton	y fa	ilure	_		Onset and Death	
B 8 - 6	_	_	S JOH AS A	CONSEQUENCE O	Du P	Juno.	naru	Mote	IDIMO	
	CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE O	P PY	Pact	Ca	100	11110	
Cat Cat	FICA	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE O	- DIC	451	9. 1		443.	
0. 5 5 5	E	reaulting in death) LAST	6		900					
DS, P.O. the death certif the attending of the attending of Mental Hygier injury, or oth		PART II. Other algnificent condition	s contributing to death bu	it not resulting	in the underlying	n Cause olven in	Pert I. 24s, WAS AN	AUTORIV	41- WEDS ALTONOV SURVIVO	
人 强色 財 四	OICAL				are arraorrying	g cadso given in	PERFOI	RMED?	4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE	
w requires the been signed pt. of Health and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and show and shows a show and show and shows a show and show and show and show and show and show and show and show and sh	MEDI					/ ^ ^	1 123	ON U	OF DEATH?  1 YES 2 NO	
Law taw	Ä	DID TOBACCO USE CONTI				UNCERTAI	TAKE!			
F VITA SICIAN: The certificate ha the State D	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outpe	6. PLACE OF DEA	OTHER:		Vals bas			
OF V HYSICIA his certif with the ked, or	¥	27. MANNER OF OEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. INJ	URY AT	6 Other (Specify) 28d. DESCRIBE HOW I	NJURY OCCURED		
NOING PHYS Refer this or r death with is marked,	BY	1 W Natural 5 Pending 2 Accident Investigation			M 1 1	YES 2 NO				
TTENO TTOR: A after d		3 Suicide 6 Could not be determined	28a. PLACE OF INJURY building, etc. (Special	— At home, term, (	street, factory, office		26t, LOCATION (Street City or Town, State)	and Number or Rura	al Route Number,	
	PE	29e. CERTIFIER (Check only 1 CERTIFYING PHYSIC	CIAN: To the best of my knowle	idge, death occurre	ed at the time, date	end place, and du	to the cause(a) and mai	nner ea stated.		
HOSPITAL FUNERAL within 72 I	COMPLI		R: On the basis of examination						e(e) and manner ea stated.	
물 물을 중	8	206. SIGNATURE AND TUTLE OF CERTIFIES	Leux	101	$\sim$	295-LICENSE NU	8594	29d. OATE SIGN	ED (Month, Clay Year)	
<b>E</b> & 9 9	٩	30. NAME AND ADDRESS OF PERSON WHO Ruth Kantor, MD	COMPLETEO CAUSE OF DEA	TH (ITEM 27) (Type,	Print)		30.		W1 10	
(_		31. DATE FILED (Month, Day, Year)	6569 N		arles St	reet	Baltimo	ore, MD		
v)		MAY 03 1995	a diwder to	Let						



mit. Pages 1; 2, 3 should

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-723 5/19/95 t.t

Items 4,5 & 6,g-723 FOR STATE REGISTRAR	, 5-3-95 per f	LAND / DEPAR	TMENT OF I		MENTA	L HYGIEN	E	, , , , , , , , , , , , , , , , , , , ,	
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATH		YEAR 3. TIME OF DE.	ATH
WILLIAM			COOK				04	95 2:09	P
4. SOCIAL SECURITY NUMBER 214- -218-12-2238 1588		(In yrs. lest birthdey) 81 52 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HR	7. DATE (Mont)	DATE OF BIRTH (Month), Par (bar) 4 / 30 / 42  B. BIRTHPLACE Country) MI			Foreign
9a. FACILITY NAME (If not institution, give a	street and number)		9b. CITY, TOWN	OR LOCATION OF	DEATH		9c. COUN	TY OF DEATH	
BON SECOUR HOS	PITAL		BAL	TIMORE	,		BALT	ro. CITY	
The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon	loc of I, form on cocarion						10d. INSIDE CILLIMITS?		
10e. STREET AND NUMBER			10	f. ZIP CODE			10g. CITIZ	EN OF WHAT COUNTRY?	,
2307 N. CALVI	ERT ST.			21218			U.5	S.A.	
11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 X Divorced	12. WAS DECEDENT EVER FORCES? 1 YES	2 XNO	If yea, a	CENDENT OF HIS beelfy Cuban, Man 3 2 X NO Spe	Ican, Puerto	17 (Specify Yes Rican, atc.)	or No-	14. RACE — American Inc Black, White, atc. Specify: BLACK	flan,
15. DECEDENT'S EDU		16a. DECEDENT'S	USUAL OCCUPATI	ON	166	KIND OF BUS	SINESS/INDU		
(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of a	work done during ma se retired.)	ost of working					
12	0	UNKNO	NWN			UNKNOV	√N		
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S	NAME (First,	Middle, Maiden	Sumame)		
WILLIAM H. COOK				RUT	н в. с	СООК			
190. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	and Number or Ru	ral Route Numi	ber, City or Tow	n, State, Zip (	Code)	
LAVERNA CLINTON			OODSIDE						
209. METHOD OF DISPOSITION 1		DE PLACE AND DATE OF ARBUTUS M	OF DISPOSITION (N	ame of	DAT	E 20c. LO		Ity or Town, State	
21. SHONATURE OF TONERAL SERVICE LIN	Jelle	La	ESTE	P BROTHI EUTAW	ERS FU				
23. PART L'Enter the diseases, or shock, or heart fellura. iMMEDIATE CAUSE (Final isease or condition resulting in death)	s	ed the desth. Do reschille.  NARCOTIC /	AND ALCOHO	ode of dying, s	uch ss cerd	flec or respi	ratory erre	st, Approxir interval   Onset sr	Betwee
Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	с	A CONSEQUENCE OF					-		
resulting in deeth) LAST	d								
PART II. Other significent condition	s contributing to deeth	but not resulting	in the underlyin	g csuse given	in Pert i.	24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY AMAILABLE PRIOR COMPLETION OF OF DEATH?	R TO CAUSE
DID TOBACCO USE CONT	RIBUTE TO CAUSE (	OF DEATH YE	S   NO	UNCERTA	AIN 🗆			1) YES 2 [	NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE OF DEAT							
XXXES 5 NO	HOSPITAL: 1 ☐ Inpatient 2XIXR/Out	tpatient 3 DOA	OTHER: 4 Nursing Hon	ne 5 🗆 Residenc	e 6 C Othe	r (Specify)			
27. MANNER OF DEATH  1 Netural 6 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year) FOUND ON 4/	FOUNI	E OF 28c. IN.		26d. DES	NOWN	JURY OCCU	JRED	
2 Accident Investigation 3 Suicide 6 XX Could not be datermined	26a. PLACE OF INJUR building, atc. (Spi	IY — At home, farm, a			281. LOC City	ATION (Street a or Town, State)	nd Number of 2307 C/	r Rural Route Number, ALVERT ST.	
	CIAN: To the beat of my known	wledge, dasth occurre	ed at the time, data		lue to the cau	se(a) and man	ner aa stated	d.	stated.
29b. SIGNATURE AND TITLE OF CERTIFIES		***		29c. LICENSE N				SIGNED (Month, Day, Year	

BALTIMORE, MARYLAND 21216-0020 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or use TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use TO FIGURE AND ASSAURED FOR THE STATE DEAT. OF Health and Mental Hygiene prior to burial, cremation, or removal.

IN PORTAINT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE

AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

111 PENN

DHMH-16 Rev 1/89

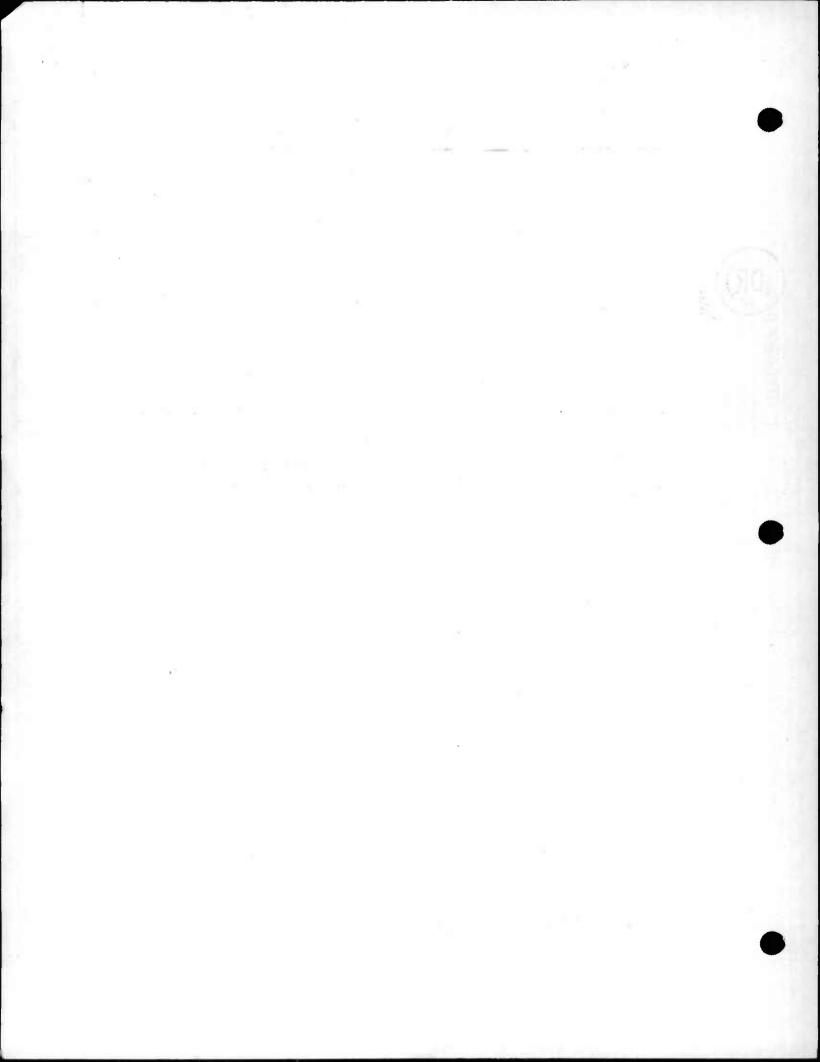
05/95

29d. DATE SIGNED (Month, Day, Year)

APRIL

O.C.ME.

PENN STREET, BALTIMORE, MARYLAND 21201



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DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician,	TO THE FURRAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit narmit Pages	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	AMBORTANT 16 form 20 is marked as form 22 should now injury as ablest bearings the modified exemises and the secondary
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95 13293 blh FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 William April 30 Henry Deans 1550 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) JAN 7, 1934 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign 239-52-8331 61 1 K KM 2 | F WAYNE Co. NC 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH DIRECTOR 3120 E. Federal Street Baltimore n/a 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. tNSIDE CITY

XX LIMITS?

1 YES 2 NO MARYLAND n/a BALTIMORE FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 0g. CITIZEN OF WHAT COUNTRY? FEDERAL 21213 3120 E. STREET UNITED STATES 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 NYES 2 NO 15 YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-It yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, stc. 1 Never Married 2 Married
3 Widowed 4 Divorced 1 YES 2 NO Specify: BY Specify: BLACK 15e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) BODY & FENDER College (1-4 or 5 +) TH MECHANIC AUTOMOBILES 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surnar SR. COY DEANS 7 CORNEL IA **ADAMS** BE 19a. INFORMANT'S NAME (Type/Print) et and Number or Rural Route Number, City or Town, State, Zip Code)

STREET, BALTIMORE, MARYLAND# 13 19b. MAILING ADDRESS (Stre 2 HAMILTON FUNERAL HOME FEDERAL 20a. METHOD OF DISPOSITION
A Burlal 2 Cremation 3 Re
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE ADAMS CEMETERY 5 - 7WAYNE COUNTY, NC 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE 23. PART 1. Enter the disesses, or complications that ceused the daeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feliure. List only one cause on each line Interval Betw **IMMEDIATE CAUSE (Final** Onset and Death disease or condition resulting in deeth) Uno Cleroti DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE 24s. WAS AN AUTOPSY 1 TYES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN \( \bar{\D} \) PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 X YES 2 - NO 1 - Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28b. TIME OF INJURY 28d, DESCRIBE HOW INJURY OCCURED Natural 5 Pending М 1 YES 2 NO ВҰ 2 Accident 28a. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide COMPLETED 6 Could not be 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. (Check only one) 2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE O.C.M.E. May 1 1995

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36. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

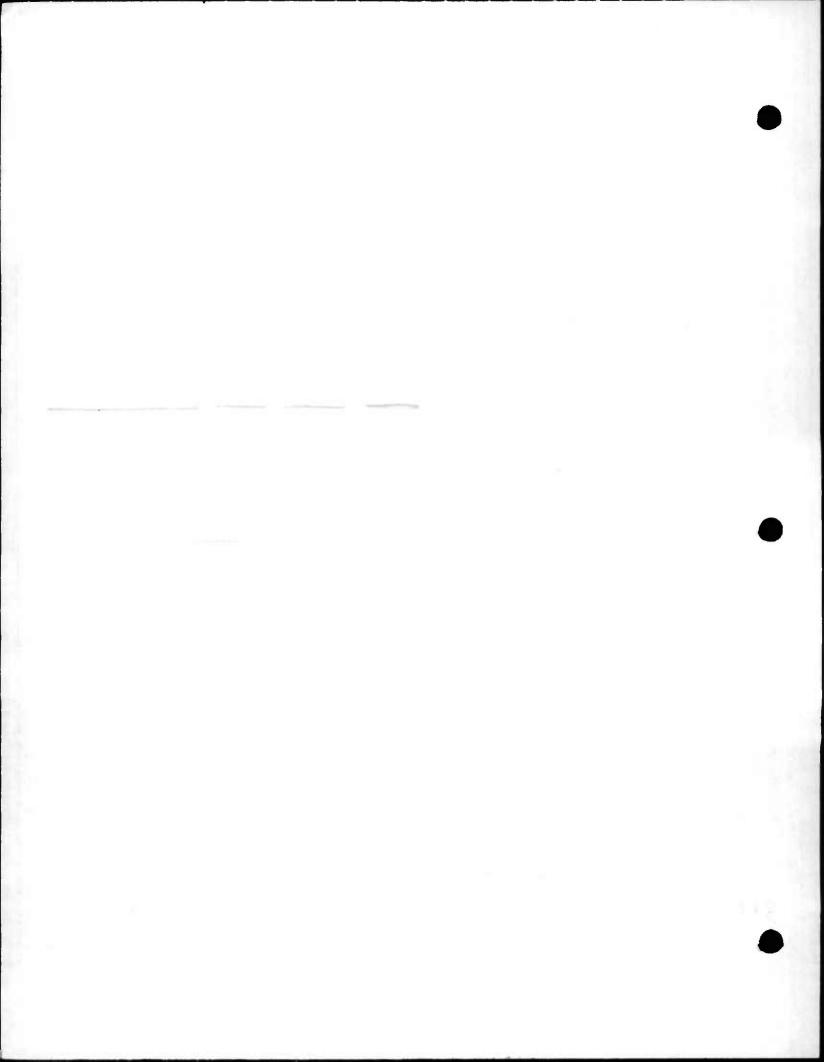
Registration of the Royalell

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MAY n 3 1995

31. DATE FILED (Month, Day, Year)

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

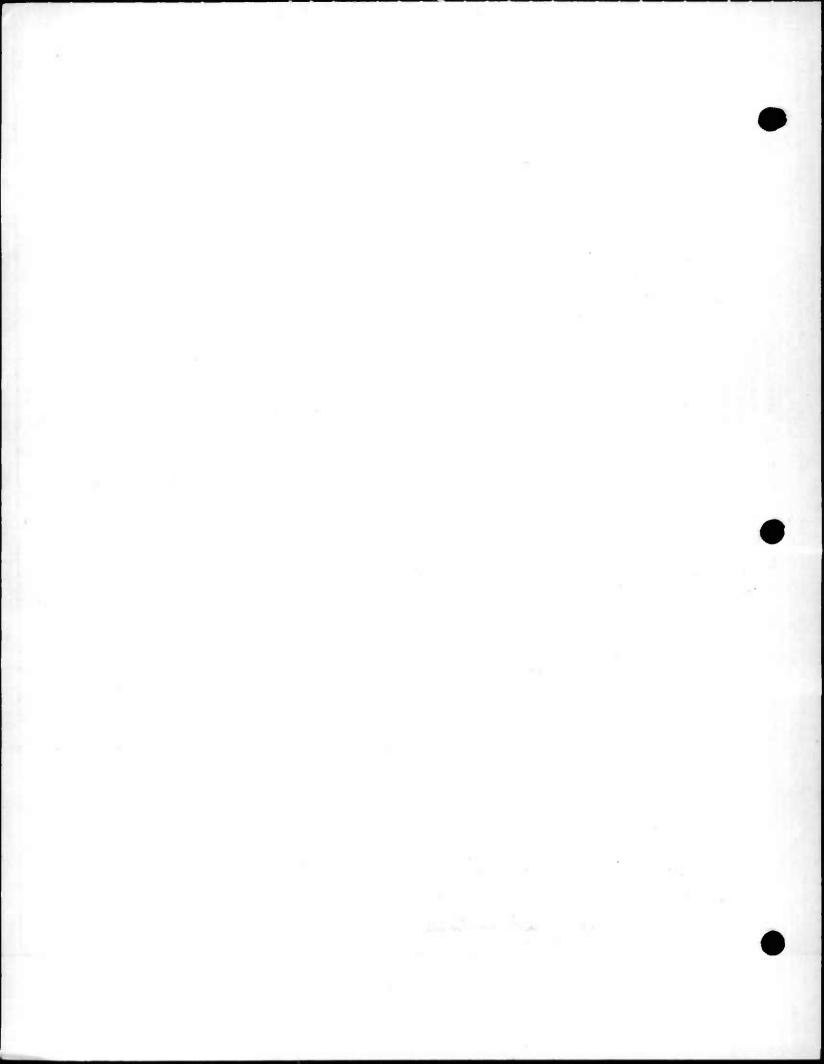
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Gordon ·llard Scitt 1155 05 0 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign 1 M 2 D F DAYS 213-09-0427 YRS. 87 Nov 10 Virginia Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give atreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Sinai Hospital Baltimore n/a 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Pikesville 1 TES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? burial-transit 8108 Streamwood Drive 21208 USA the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) ВҰ 1 TES 2 NO Specify. Specify: the 3 X Widowed 4 Divorced Bl.ack signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as Health and Mental Hygiene prior to burial, cremation, or removal. 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY (Specify only high Ħ Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 8th grade Crane Operator Bethlehem Steel Corporation 17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Maiden Surname) retained by ĕ Caleb Dillard BE Ellen notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 21133 Rudolph Dillard 3661 Water Wheel Square Randallstown, Maryland Pe 20a METHOD OF DISPOSITION
1 X Buriel 2 Cremation 3 Ram 20b. PLACE AND DATE OF DISPOSITION (Name of May 5 20c. LOCATION — City or Town, Stata must Maryland National Mem. Park 4 Donation 5 Other (Specify) Laurel, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSE examiner 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216 cremation, or removal event, the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, Approximata ahock, or heart fallure. List only one ceuse on each line. Interval Bety IMMEDIATE CAUSE (Fine) **Onast and Death** disease or condition Myocardia Acute resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Orongry traumatic CERTIFICATION YNS Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events or other DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other eignificent conditions contributing to death but not recuiting in the underlying ceuee given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE Mulnylvition 1 TES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be HOSPITAL OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) this certificate h with the State I HOSPITAL:
1 pringerient 2 = ER/Outpetient 3 = DOA OTHER: 1 TES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 10 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED. 1 Natural 1 YES 2 NO After If BY Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be DIRECTOR hours after Item 28 is 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL TO THE FUNERAL (De filed within 72 h 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CENTIFIER 29d. DATE SIGNED (Month, Day, Year) BE A52402321199523 05, 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael



MAY 03 1995

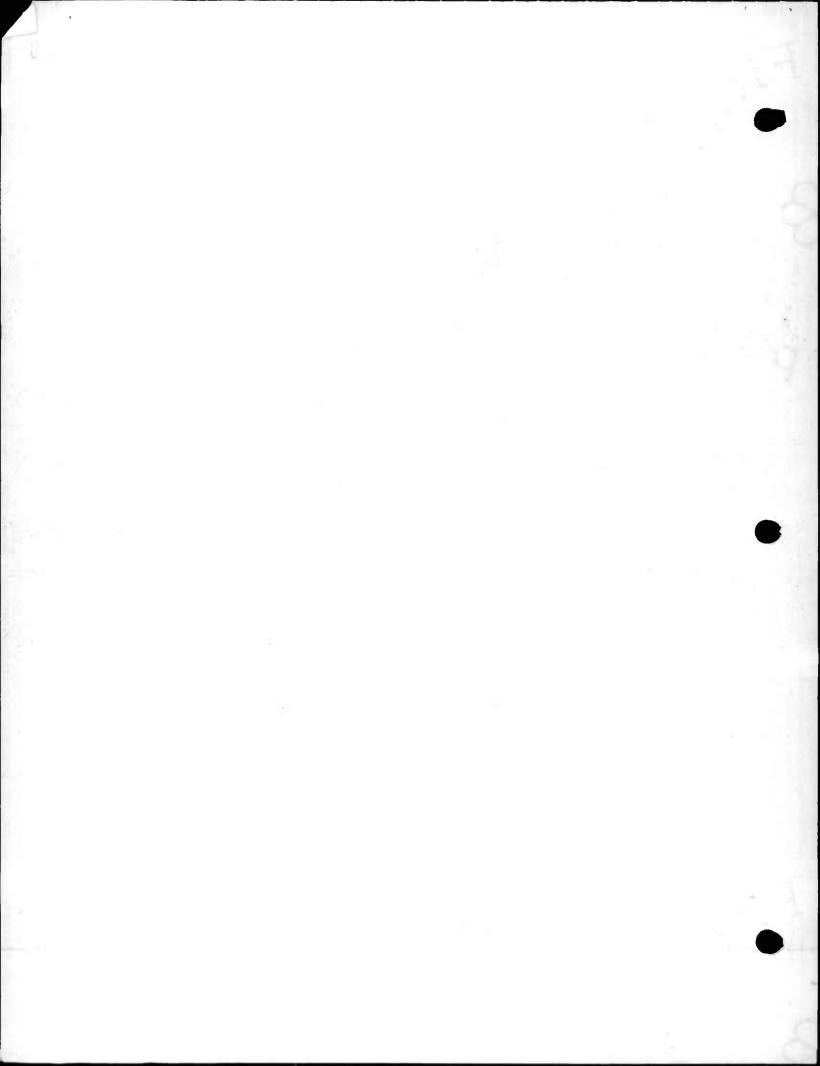
BAL	PITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death	COAL MIDECATION States this conditioned has been also also also also also also also and accomplished to be at a
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DIVISION OF VITAL RECORDS, P.O. BOX 68/60	A	Y
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		1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
		DECEDENT'S NAME (First, Middle, Last)     Cleveland	Dar	niels			2. DATE OF DEATH APTIL 30, 199			8;31 AM	
- D		251-07-9174	5. SEX 6. AGE (in yrs. lest 78	YRS. IF U	NOER I YEAR THE DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Mooth, Day, bear)		8. BIRTHPLA	AROLINA	
. 2. 3 should	стоя	99. FACILITY NAME (If not institution, give streets)  513 Roundview Road RESIDENCE OF DECEMENT			CITY, TOWN O	R LOCATION OF D	EATH	9c. COUN	TY OF DEATH	н	
if. Pages 1	DIREC	100. STATE 106. COUNTY MARYLAND	n/a	10c. CITY, TO	NN OR LOCAT BALTIM				- I v	d. INSIDE CITY , LIMITS?	
in. ansit permit.	VERAL	100. STREET AND NUMBER 513 ROUNDVIEW ROA	D		101.	ZIP CODE 2122	25	UN IT	ZEN OF WHAT		
215-0020 attending physician. se as the burial-transit	BY FUNI	11. MARITAL STATUS 1 Never Married 2 Married 2 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARI FORCES? 1 ☐ YES 2 ☐ H IF YES, GIVE WAR OR DATES	WED O		cify Cuben, Mexica	NIC ORIGIN? (Specify ) an, Puerto Rican, etc.) y:	fes or No	Black, WI	American Indian, hite, etc. BLACK	
D 27 Spital or led for u	COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade oc Elementary/Secondary (0-12)	(Gh College (1-4 or 5 +)	CEDENT'S USUA We kind of work of Do NOT use retin	one during mos ed.)	N at of working	166. KIND OF B	BUSINESS/INDU STAURAN			
ज हिन्द्र	BE CO	17. FATHER'S NAME (First, Middle, Last) SAMUEL DANIEL				BAM		IIELS			
	5	190. INFORMANT'S NAME (Type/Print)  LORETTA DANIE	LS	513 F	ROUNDV	IEW ROAD	Aoute Number, City or R D, BALTIMO	RE, MD	212		
FINORE,  Page 6 may be rai director, page liner must be		20e, METHOO OF DISPOSITION  XX Buriel 2 Cremetion 3 Remov. 4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICE!	MARY		NATION		.5-5	LAUREL			
SAL r death he fune al.		> Franci	/ Acor		March 1101 E	Funeral . North	Home East Avenue/Ba	ltimor		21202	
24 ion		23. PART I. Enter the diseases, or contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained the contained	mplications that caused the del at only one cause on each line.	cula		enden	1	piratory arre	ent,	Approximata Interval Batween Onset and Daeth	
icate be execuphysician and the prior to bur er traumatic	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEO DUE TO (OR AS A CONSEO	UENCE OF):				_			
at the death certified by the attending and Mental Hygien	CAL CEI	PART II. Other algorificant conditions			underlying	ceuse given in		AN AUTOPSY ORMED?	AWA	RE AUTOPSY FINDINGS ILABLE PRIOR TO	
law requires that as been signed bept, of Health and 23 shows and	: MEDI	DID TOBACCO USE CONTRI	BLITE TO CAUSE OF DEAT			UNCERTAII	1 □ YES	2 NO	OF (	MPLETION OF CAUSE DEATH?  YES 2 NO	
The late has ate De ate De ate De	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		OF DEATH (Ch		V	6 Other (Specify)			*	
오 돌 돌 <b>호</b>	ву рну	27. MANNER OF DEATH  1 Natural 5 Pending Investigation	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY	28c. INJU WOF	RY AT	26d. DESCRIBE HOW	INJURY OCCU	JRED		
OR ATTENDING DIRECTOR: After hours after death tem 28 is mai		3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — At hon building, etc. (Specify)	ne, farm, street,	tactory, office		28t. LOCATION (Stree City or Town, Stell	t end Number o e)	v Rural Route	Number,	
3 7 Z	COMPLETE		N: To the best of my knowledge, dea On the beele of examination and/or in							I manner ee stated.	
TO THE HOSPIT TO THE FUNERA De filed within 7	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER	4 mo		_	29c. LICENSE NUN	ABER 373	29d, DATE	SIGNED (Mor	oth, Day, Year)	
5		30. NAME AND ADDRESS OF PERSON WHO	VMT, MD 200	27) (Type, Print)	Jio H	11 Ave	Bmoz, 1	nn 2	1217		
		MAY 0 3 1995 Jul	32 REGISTRAR'S SONATURE								



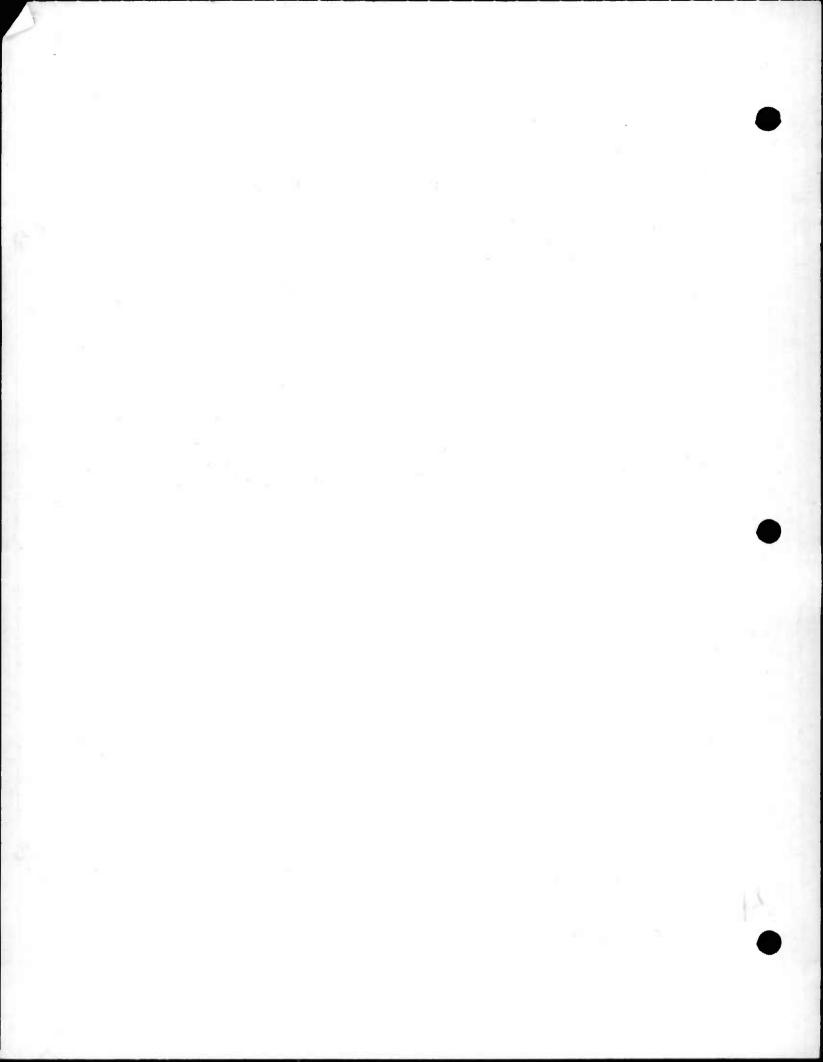
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		1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF HEALTH AND ICATE OF DEATH	MENTAL HYGIENE REG. NO.	
		1. DECEDENT'S NAME (First, Middle, fast)	FIELDS			2. DATE OF DEATH MONTH DAY	3. TIME OF DEATH
2, 3 should		4. SOCIAL SECURITY NUMBER 2/3-18-3934	5. SEX 6. AGE	(In yrs. lest birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) March 17, 19	B. BIRTNPLACE (State or Foreign Country)
	OR	90. FACILITY NAME (If not institution, give s MERCY Medic	cel Centes	_	9b. CITY, TOWN OR LOCATION OF Baltimore	DEATN 9	c. COUNTY OF DEATH
<del>-</del>	DIRECTOR	10a, STATE 10b, COUNTY	NIA	0	y, town or Location a (timore		10d. INSIDE CITY LIMITS?  1 Y YES 2 NO
physician. burlal-transit permit. Pages	FUNERAL	1652 N . Y	Appleton	Street	101. ZIP CODE 2/2/	7	Dg. CITIZEN OF WHAT COUNTRY?
	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IF FORCES? 1 1 YES	2 NO	13. WAS DECENDENT OF HISP If yea, specify Cuban, Mexi 1 YES 2 NO Spec		No — 14. RACE — American Indien, Black, Whita, atc. Specify: BL
or attend	LETED	15. DECEDENT'S EQU- (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	18a. DECEDENT'S (Give kind of v life. Do NOT us	USUAL OCCUPATION work done during most of working be retired.)	16b, KIND OF BUSINE	SS/INDUSTRY
the hospital e detached for t once.	COMPLET	12th grade U	inknown	4.60	SE W, FE  18 MOTHER'S P	IAME (First, Middle, Maiden Sun	name)
s retained by 5 should be notified at	TO BE	19a. INFORMANT'S NAME (Type/Print)  Bouldware Fields		19b. MAILING	ADDRESS (Street and Number or Rura	- ·	tere, Zip Code) . Z1Z17
e 6 may be ector, page must be		20a, METHOD OF DISPOSITION  1 X Buriel 2 Cremation 3 Ram  4 Donation 5 Other (Specify)		PLACE AND DATE O	OF DISPOSITION (Name of place)	n Street	ION - City or Town, Stata
death. Pag funeral dir examiner		21. SIGNATURE OF FUNERAL SERVICE LIC	Indhe	<u> </u>	22. NAME AND ADDRESS OF HANGE F. H.	FACILITY West	La B N. W.
hours after of filled in by the on, or removal.			emplications that cause list only one cause on e	d the death. Do reach line.	not antar the mode of dying, su	ich as cardiac or reapirate	Interval Between
completely filled rial, cremation,		iMMEDIATE CAUSE (Final disease or condition reaulting in dasth)	Chronic	a consequence of	Inchie Pul	Rumary Dr.	Sease 15 year
and com burial,	TION	Sequentisity list conditions, if sny, leading to immediate	Palem	CONSEQUENCE OF	Fibrosis	<i>U</i>	15 years
nding phy Hygiene p	CERTIFICATION	csuse. Entar UNDERLYING CAUSE (Disesse or injury that initiated events resulting in daath) LAST	DUE TO (OR AS A	A CONSEQUENCE OF	7):		
the death the atte d Mental	占	PART II. Other significant condition	a contributing to death b	out not resulting		n Part i. 24a. WAS AN AUT	
		Lower	Gastro infe	8 mal	Eleding	1   YES   758	COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO
The law are has b are Dept.	PHYSICIAN: MEDI	DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	CONTRIBUTE TO	CAUSE O	26. PLACE OF DEATH (COTHER:		
NG PHYSICIAN: tter this certific auth with the Si marked, or II		1 YES 2 NO.  27. MANNER OF DEATN  Setural 5 Pending	1 Inputlant 2 ER/Out	28b. TIM	4 Nursing Home 5 Rasidence E OF 28c, INJURY AT WORK?	6 Other (Specify) 28d. DE\$CRIBE NOW INJU	RY OCCURED
OR ATTENDING PHYSICIAN: DIRECTOR: After this certifica hours after death with the St Nem 28 is marked, or N	ED BY	2 Accident Investigation 3 Suicide a Could not be datermined	28s. PLACE OF INJURY building, stc. (Spe-	f — At home, tarm, s		28f. LOCATION (Street and a City or Town, State)	Number or Rural Route Number,
TAL OR VAL DIR 72 hour	COMPLETED				od at the time, date and place, and de		as stated. us to the cause(s) and manner as stated.
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: II	BE CO	29b. SIGNATURE AND TITLE OF CENTRIES		<b>7</b> 0 -	29c. LICENSE N		od. DATE SIGNED (Month Dey, Year)
5 5 3 M	2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	EATN (NEM 27) (Type,	Print) 14 10 (1)	179	04/29/95
		31. DATE FILED (Month, Day, Year)	SEINHH 32 REGISTRAR'S SIGN	KD, M-C	). MERCY M	EDICAL CENT	EK. BALTO, MD
		MAY U 3 1995 /4	hi d'évoleon Ran	dall			



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		1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPAR CERTIF	TMENT OF	HEALTH AND F DEATH	MENT	AL HYGIENE REG. NO.			
		1. DECEDENT'S HAME (First, Middle, I	ast)				2, DAT	TE OF DEATH			TIME OF DEATH
		Sylvia		Fleet				7 02,	199	5 :	10:30 A
Pin		4. SOCIAL SECURITY NUMBER 229-16-4468	1 M 2 TEF	(In yrs. last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	11	e of BIRTH oth, Day, Year) -6-24	6.	Country)	ACE (State or Foreign
3 should	œ	9a. FACILITY HAME (If not institution, of MARYLAND GEN		A.T.		OR LOCATION OF E		1	9c. COUNTY		Н
1. 2,	стов	RESIDENCE OF DECEDEN		AL	BAL	TIMORE	CIT	Y	N	/A	- 10
Pages	DIRE	MD 10a. STATE 10b. CO	N/A		Y, TOWN OR LOCA BALTIM	ORE CIT	Ϋ́				d. INSIDE CITY LIMITS? XYES 2 \( \) HO
ın. ransit permit.	VERAL	915 N. LINWO	OD AVENUE		10	2120	5			S.A	T COUNTRY?
215-0020 attending physician. se as the burial-transit	BY FUNER	11. MARITAL STATUS  1 Never Married 2 Married  3 Wildowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES	2 X HO	If yes, s	CENDEHT OF HISPA pecify Guban, Maxic S 2 NO Speci	an, Puert	ilH? (Specify Yes o o Rican, etc.)		RACE — Black, W	
attend use as	9	15. DECEDENT'S (Specify only highest)	EDUCATION (rade completed)	16a. DECEDENT'S	USUAL OCCUPATI	IOH	10	Sb. KIHD OF BUSIN	IESS/INDUS	TRY	
Z g V	LET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT us	e retired.)			~~====		_	
he hospit detached once.	COMPL	12. 17. FATHER'S NAME (First, Middle, Last	N/a	FACTO	RY WOR			GOTTLI		0.	
. 0 -		GEORGE	COLEMAN			1		, Middle, Malden Su			
retained by 5 should b notified a	BE	19a. INFORMANT'S HAME (Type/Print)	COLEMAN	19b. MAILING	ADDRESS (Street	ELIZA		HARR	ELL State 7/2 Co	ofa)	
5 5 5	일	CAROLYN PERRY				WOOD AV		ALTIMO			1205
may be or page		20a, METHOD OF DISPOSITION 1 X Buriel 2 Cremetion 3	200	D. PLACE AND DATE O	F DISPOSITION (N			_	TION — City		
E 6 6		4 Donation 5 Other (Specify)		ARBUTUS	MEMOR:	IAL PK	5/	6 ARBI	UTUS	, MD	
r death		21. SIGNATURE OF FUNERAL SERVICE	Croma	rtie:		N. CAR		BETTS I	FUNE	RAL	HOME
ompletely fille il. cremation.		23. PART I. Enter the diseases, shock, or hear settle iMMEDIATE CAUSE (Finel disease or condition resulting in death)	a. Metastati	ech line.	inoma	oda of dying, au	ch as ca	rdiac or raaptre	tory erreet	,	Approximata interval Between Onset and Death MONThs
th certificate be ending physician in Hygiene prior to or other traus	CERTIFICATION	Sequentially list conditions, if sny, leeding to immediate couse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	c	A CONSEQUENCE OF							
that the ded by the hand Mer	MEDICAL C	PART II. Other significant condi	tione contributing to death b	out not resulting l	n the underlyin	ig cause given in	Part I.	24a. WAS AN AU PERFORM!	ED?	AVA	RE AUTOPSY FINDINGS ILABLE PRIOR TO MPLETION OF CAUSE DEATH?
law requires that been signed ept. of Health 23 shows am		DID TODA CCO LICE CO	ATTOINITE TO GALLOT							1 [	YES 2 NO
23 Pept	SICIAN:	DID TOBACCO USE CO. 25. WAS CASE REFERRED TO MEDICA		26. PLACE OF DEAT			N□				
E 88 5	Sici	EXAMINER?	HOSPITAL:		OTHER:						
SICIA certif	主	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME	OF 28c, IN.	ne 5 Residence		er (Specify) ESCRIBE HOW INJ	URY OCCUR	ED	
NG PHYS fler this c eath with	ВУ Р	1 Natural 5 Pending 2 Accident Investigati	(Month, Day, Year)	IHUC		YES 2 HO					
TTENDI CTOR: A after do	TEO .	3 Suicide 6 Could not determine		f — At home, farm, st	treet, factory, offic	ce	281. LO	CATIOH (Street and y or Town, State)	Number or F	Rural Route	Number,
1 2 Z	COMPLE		HYSICIAN: To the best of my know							luse(s) and	f manner as stated.
TO THE HOSPITAL TO THE FUNERAL be filed within 72 IMPORTANT: II	TO BE C	29b. SIGNATURE AND TITLE OF CENT	Rugan	Zur	>	29c. LICENSE NU D1634			May		nth, Day, Year)
4			M.D. c/o Maryl	and Gene		pital				•	
		31. DATE FILED (Month, Day, Year)  MAY () 3 1995	32. REGISTRAR'S SIGN								



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		1 - STATE REGISTRAR	TE STATE OF MANYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE							
		1. DECEDENT'S NAME (First, Middle, Last)	RIAM FEL	LA		2. DATE OF DEATH MONTH DAY	YEAR 3. TIME OF DEATH 95 0145 Am			
		4. SOCIAL SECURITY NUMBER 218-18-9050		71 YRS. MONT	NDER 1 YEAR IF UNDER 24 HRS. HS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)  VIRGINIA			
3 should	E	9a. FACILITY NAME (If not institution, give a ST. AGNES HOSP! 900 CATON AUG	7794		CITY, TOWN OR LOCATION OF E	5-3-23 PEATH 9c. CO	DUNTY OF DEATH			
ss 1, 2,	DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY			VN OR LOCATION		10d. INSIDE CITY			
physician. burial-transit permit, Pages 1,		MARYLAND BAL	HIMORE		UTUS		LIMITS?			
	FUNERAL	100. STREET AND NUMBER 55/5 SCLMA	Avenue		101. ZIP CODE 2/22		U.S.A.			
ing the	BY	11. MARITAL STATUS  1 Never Married 2 Married  3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U. FORCES? 1 TYES 2 IF YES, GIVE WAR OR DATE	2 NO	13. WAS DECENDENT OF HISPA If yes, specify Cuban, Maxic 1 YES 2 NO Speci		14. RACE — American Indian, Black, White, etc.  Specify:			
al or	PLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	life. Do NOT use retir	one during most of working	T, HLE	-			
e de B	COMPL	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S N	AME (First, Middle, Malden Surname)				
\$ 8 a	411	JAMES Ce:	STEN BRAD			IE COCILE				
- C =	2	George J. Fe	114	5515 S	SELMA AUEN	Route Number, City or Town, State, 2	ce, MD. 21227			
. 65		20a, METHOD OF DISPOSITION 1	20b. PL cerpeter	ACE AND DATE OF DIS	POSITION (Name of ace)	DATE 20c. LOCATION -	- City or Town, State  ORE, MARYLAND			
death. Page 6 m s funeral director, l. examiner must	Ŋ	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	LOK OKIN	22. NAME AND ADDRESS OF F	ACILITY DANS HOME	ARBUTUS,			
0 = 0		100	(======================================				ARBUTUS, MARYLAND 21227			
in by rem	1		omplicationa that caused th Liat only ona cause on each	a death. Do not a	ntar tha moda of dying, suc	ch as cardiac or respiretory a	Approximate interval Between			
rted within 24 hos completely filled ial, cremation, or event, the m		IMMEDIATE CAUSE (Final disease or condition resulting in death)	DUE TO (OR AS A CO	Denal DISEOUENCE OFF	! failure		Onset and Death Ten Years			
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certifi the	PHYSICIAN:	27. MANNER OF DEATH	1 Sinpatiant 2 ER/Outpatie  26a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	Nursing Home 5 Residence	8 Other (Specify)  28d. DESCRIBE HOW INJURY OF	CCURED			
DING PHYS After this of death with	ВУ Б	1 Natural 5 Pending 2 Accident Investigation			WORK?	111111111111111111111111111111111111111				
TTEN TOR: after	ETED	3 Suicide 6 Could not be 4 Homicide detarmined	28a. PLACE OF INJURY — building, etc. (Specify)	At home, farm, atreet,	factory, office	261. LOCATION (Street and Number City or Yown, State)	er or Rural Route Number,			
보 되었는	COMPLETED	one) 2 MEDICAL EXAMINE	R: On the beals of examination an			to the cause(s) end manner as st time, date and pleca, and dua to	ated. tha cause(a) and manner as stated.			
TO THE HOSPIT TO THE FUNERA De filed within 7 IMPORTANT: I	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER	Sin Medic	of Resid	ent ST. Agne	1	TE SIGNED (Month, Day, Year)  1 Ay , 2 , 1995			
10		20. NAME AND ADDRESS OF PERSON WHO	T. Agmes Hos	spital	900 S.	Caton Ave.	Batto MD 21229			
		MAY 0 3 1995 July	32. REGISTRAR'S SIGNATU							

Pages 1, 2, 3 should

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funeral director, page 5 should be

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	TO THE HOSPITAL DR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by to be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or remov	IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ELMER FRANKLIN GERMEROTH Apr 29 1995 6:45 am 4. SOCIAL SECURITY NUMBER B. AGE (In yrs. last birthday) 7. DATE OF BIRTH NOVEMBER 10, 1921 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 X M 2 - F DAYS HOURS BALTIMORE MARYLAND 216-14-4178 73 YRS 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Saint Joseph Medical Center Towson, Maryland Baltimore RESIDENCE OF DECEDENT 10b. COUNTY 18c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE MARYLAND BALTIMORE CITY 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 4600 LUERSSEN AVENUE 21206 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 XXYES 2 NO 14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Maxican, Puerto Ri 1 ☐ YES 2 (¥ NO Specify: 1 Never Married 2 X Married IF YES. GIVE WAR OR DATES BY 3 Widowed 4 Divorced Specify: WWIIT WHITE ED 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe COMPLET Elementary/Secondary (0-12) College (1-4 or 5 +) N/A 12 MILLWRIGHT WESTERN ELECTRIC ONCE. 17. FATHER'S NAME (First Miciclio Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIAN M. KUHN Ħ PETER GODFRIED GERMEROTH notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Pural Route Number, City or Town, State, Zip Code) 9 FRANCES E. GERMEROTH 4600 LUERSSEN AVENUE BALTIMORE, MARYLAND 21206 pe 20a, METHOD OF DISPOSITION
1 IX Burlat 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must 4 ☐ Donation 6 ☐ Other (Specify) MEADOWRIDGE MEMORIAL PARK MAY 3, 1995 HOWARD COUNTY, MARYLAND examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY LASSAHN FUNERAL HOME, INC. 7401 BELAIR ROAD BALTIMORE, MARYLAND 21236 Dottor Massam medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Approximats** shock, or heart fellure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Finel Onset and Death the disease or condition . SHOCK traumatic event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF): GASTROINTESTINAL BLEEDING CERTIFICATION Sequentielly list conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING STRESSGASTRITIS CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): reaulting in death) LAST **DUODENAL ULCER** 6 injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO shows any STATUS POST BRAIN SURGERY and METHICILLIN 1 - YES 2 NO COMPLETION OF CAUSE DF DEATH? RESISTANT STAPHYLOCOCCUS AUREUS BRONCHITIS 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) OTHER: 1 TES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 6 27. MANNER OF OEATH 28s. DATE OF INJURY 26b. TIME OF 28c. INJURY AT WORK? marked. 28d. DESCRIBE HOW INJURY OCCURED Natural Accident INJURY M 1 YES 2 NO BY Investigation 26s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 69 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 28 4 Homicide Item 29s. CERTIFIER
(Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(s) and manner as stated. -2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 296. SIGNATURE AND TITLE OF CERTIFIER

A. P. ZALDWNDO, M.D. (by Effaying M.D.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) D 29308 9 A.P. ZALDUONDO M.D. 7620 YORK ROAD TOWSON, MARYLAND 21204 32. AGGIST PAR'S SONATURE

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A P. ZALDUGNDO M.D. 7620 YORK ROAD TOWSON MARYLAND 21234

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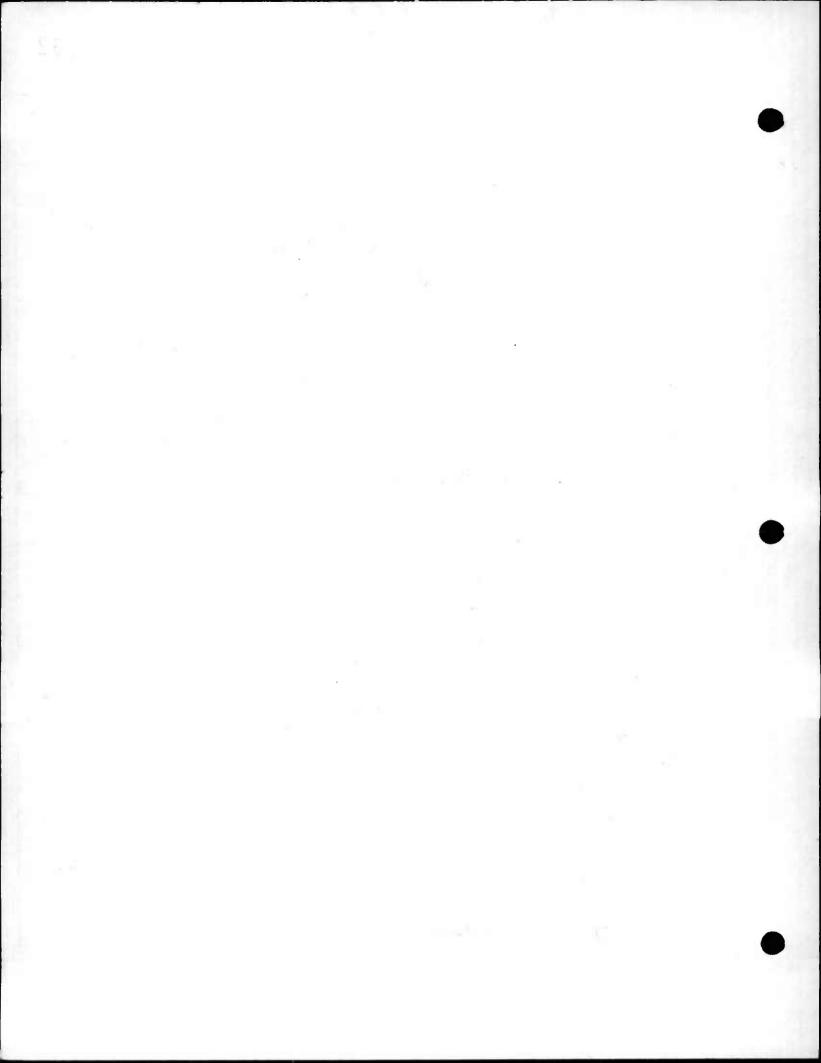
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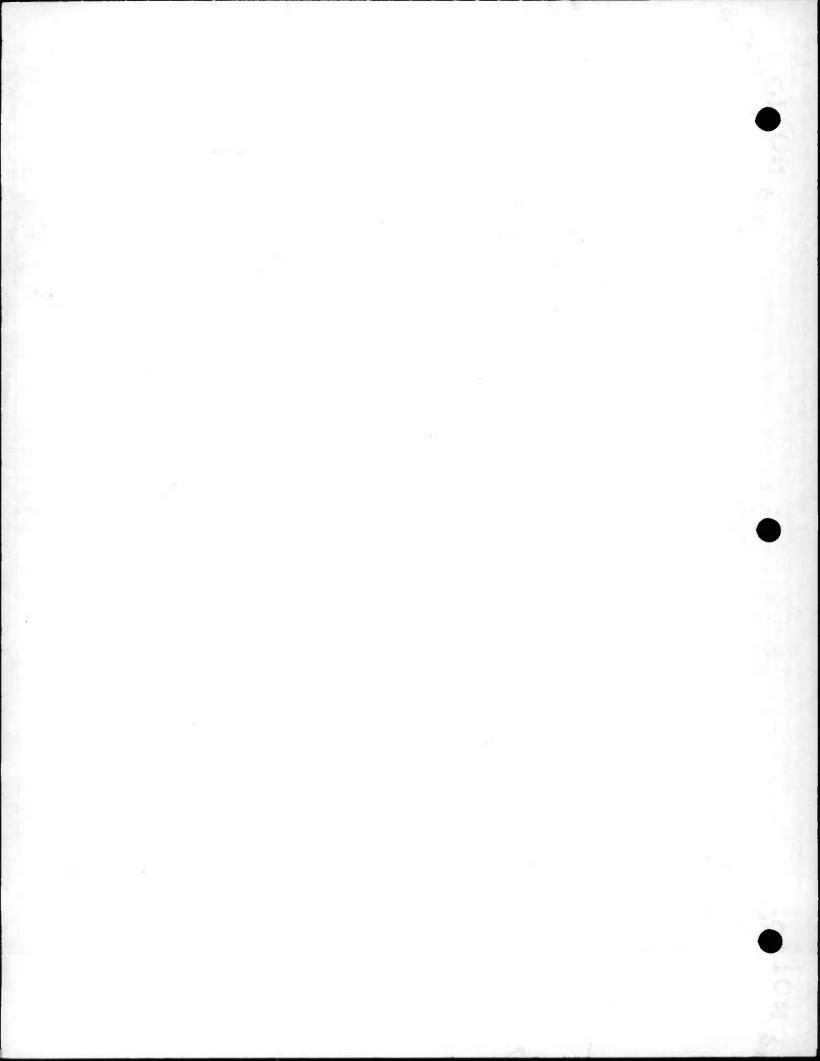
1, DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN HOPI YEAR 995 10-13 Am 30 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year 5. SEX 6. AGE (In yrs. last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State of Foreign 219-26-1 X M 2 - F 5 5 939 10 may Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give OR LOCATION OF DEATH 9c. COUNTY-OF DEATH 5222 Bal DIRECTOR Sa RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a, STATE 10d. INSIDE CITY Ja 1 VES 2 NO )a executed within £4 hours after death. Page 6 may be retained by the hospital or attending physician, a and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. FUNERAL 10s. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 522 Ave Inden Heights 5 21 5 WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or Noif yea, specify Cuban, Maxican, Puarto Rican, etc.)
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 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Merried 2 Married IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Dive COMPLETED 15. DECEDENT'S EDUCATION
Decify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY dary (0-12) Co Supt Maintenance. 1a Ima once. 18 MOTHER'S NAME (Fire at a BE toug 35€ ams notified 19b. MAILING ADORESS 2 roly 222 110 21215 pe 200-PLACE AND OATE OF DISPOSITION (Name of contract) Congetory of piper place) + mass METNOD OF DISPOSITION SATE 5757 20c. LOCATION must Burial 2 Cremation 3 Ren rel trom State in 6 Other (Specify) t mona other traumatic event, the medical examiner OF FUNERAL SERVICE/LICENSEE 22. NAME AND ADDRESS OF FACILITY arch u JR 21215 Mental Hydiene prior to burial, cremation, or removal. 23. PART I Enter the diseases, or complications that clueed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate interval Between iMMEDIATE CAUSE (Final disease or condition Onset end Death 31/2 YR 6 resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION DIRECTOR: After this certificate has been signed by the attending physician and hours after death with the State Dept. of Health and Mental Hygiene prior to bur Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leeding to immediate cause. Enter UNDERLYING the death certificate be CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) thet initiated events resulting in death) LAST 6 Injury, PART ii. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS law requires that PERFORMED? MAIL ARLE PRIOR TO 23 shows any COMPLETION OF CAUSE OF DEATH? 1 TYES 1 - YES 2 - NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH NO UNCERTAIN YES PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN Ch ock only one) OR ATTENDING PHYSICIAN: The Hem OTHER: 1 YES 2 1 | Inpetient 2 | ER/Outpetient 3 | DOA 6 Other (Specify) 0 27. MANNER OF DEATH 26a, DATE OF INJURY marked, 26b. TIME OF 26c. INJURY AT 28d. DEŞCRIBE NOW INJURY OCCURED 1 YES 2 NO BY 2 Colden Investigation 28 Is n 3 Sulcide 28a. PLACE OF INJURY — At homa, farm, atreet, factory, office building, atc. (Specify) 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicid tem 29a, CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. THE FUNERAL C HOSPITAL Ŧ TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 investigation, in my opinion, death occurred at the time 29b. SIGNATURE AND TITLE OF CERTIFIE 29c, LICENSE NUMBER BE 29d. OATE SIGNED (Month, Day, Year) 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 415 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 2111 3 1995 0

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



		1 - STATE REGISTRAR	STATE OF MARYL	LAND / DEPAR CERTIF	RTMENT	OF H	IEALTH DEA	I AND W	IENTA	L HYGIE				
		1. DECEDENT'S HAME (First, Middle, Last)							2. DATE	OF DEATH		YEAR 3.	TIME OF DEATH	
		Mary Alice	T	Higg	-		T		Apr	il	30, 1	995	9:37 F	M /
pino		213-24-1758  9a. FACILITY HAME (If not institution, give s	1 🗆 M 2 🔀 F	(In yrs. last birthday) 65 YRS.	MONTHS	DAYS	HOURS	MIN.	(Mon	of BIRTH	21, 1929	Mary	rland	lgn
1, 2, 3 should	TOR	3 S. Hilton Stree					more	TIOH OF DEA	ATH		- 224	n/a	н	
permit. Pages 1,	DIRECTOR	MD 10a. STATE 10b. COUNTY	n/a		altin								d. INSIDE CITY LIMITS?	0
ışı	FUNERAL	3 S. Hilton Stre	et			101	212					J.S.A	T COUNTRY?	
21215-0020 al or attending physician. for use as the burial-transit	B	11. MARITAL STATUS  1 X Never Married 2 Married  3 Wildowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1   YES IF YES, GIVE WAR OR D	IN U.S. ARMED : 2 HO DATES		If yes, sp	ecify Cubi	OF HISPANI en, Mexican Specify:	C ORIGII , Puerto	1? (Specify Y Ricen, etc.)	ee or No 1	4. RACE — Black, W Specify:	American Indian, hite, etc.	,
21215-0 pltal or attending of for use as the	PLETED	15. DECEDENT'S EDUI (Specify only highest grade Elementary/Secondery (0-12) 7th	CATION completed) College (1-4 or 5+)	16a. DECEDENT'S (Give kind of life Do NOT us	work done o	during mo					WPLOYE			
YLAND 2. by the hospital of be detached for at once.	1 1	17. FATHER'S NAME (First, Middle, Last)  Rev. T. William	Higgins	JEANS IN	E33/	AID	18. MOT	THER'S HAM	E (First,	Middle, Maide				
MARY retained by S should to	TO BE	190. IHFORMANT'S NAME (Type/Print) Cleola A. John:		19b. MAILING	ADDRESS	(Street e	nd Numbe	or or Rural Ro	oute Num	her City or To	or, State, Zip CORE, MI	Cordel	1218	
m a a a		20e. METHOD OF DISPOSITION 1 以如irlet 2 □ Crematton 3 □ Remo	201	b. PLACE AND DATE	OF DISPOS	ITIOH (Na	me of		DAT	E 20c. L	OCATION — CII	ty or Town,	State	
ALTIMOR death. Page 6 ma e funeral director. p		4 Donation 6 Other (Specify)		KING ME	_	_	PARK HD ADDRE	ESS OF FACI	5-5	KAI	NDALLS	I UWN,	טויו	
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ithir 24 hours letely filled in the emation, or re-		IMMEDIATE CAUSE (Fine)	END STAGE	aach lina.		the mo	de of dy	/ing, auch	aa cen	diac Dr reap	piratory arres	t,	Approximate interval Bets Onset and 5	ween Death
OX 6876  be executed cian and comic to burial, raumatic ev	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR AS /	A COHSEQUENCE OF	PF):									
P.O. h certific anding pl Hygiene or othe	CERTIF	that initiated eventa resulting in deeth) LAST	DUE TO (OR AS A	A CONSEQUENCE OF	F):									
RDS at the d by the and Mer	MEDICAL (	PART II. Other algorificant condition. SEIZUKES	DIFAETE		In the un	derlying	) cause	given in P	ert I.	24a. WAS A	RMED2	AVA COI	RE AUTOPSY FIND ALABLE PRIOR TO MPLETION OF CAU DEATH?	
E Gera		DID TOBACCO USE CONTR	RIBUTE TO CAUSE C	OF DEATH YE	ES 🗆 N	40 <u></u>	UNC	CERTAIN	_			1	YES 2 NO	
VITAL AN: The law tificate has e State Dep	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	TH (Check of									
the the	HYS	1 YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Outs 26a. DATE OF IHJURY	tpetient 3 DOA		Ing Home		esidence 6	_		INJURY OCCU	nen.		
After Jeath	BY	1 Netural 5 Pending Investigation	(Month, Day, Year)  26e. PLACE OF INJURY	1NJ	JURY M	1   Y	RK? YES 2	HÓ						
DIVISION DIRECTOR: After hours after death item 28 is ma	ETED.	3 Suicide 6 Could not be determined	building, atc. (Spe	ecffy)					City	or Town, State			Number,	
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TO THE HOSPIT TO THE FUNER De filed within 7	TO BE (	296. SIGNATURE AND TITLE OF CERTIFIER	MEDICAL RE	SIDENT			29c. LICI	ENSE NUMB	ER		29d. DATE S	AY	onth, Day, Year)	
1	Ĕ	30. HAME AND ADDRESS OF PERSON WHO	- A : 1 =	EATH (ITEM 27) (Type, DSFITAL	Print)	CA	TON .	AVE.	BRU	i. MD	2125	9		
_ 2		31. DATE FILED (Month, Day, Year)  NAAV 0 9 1995	32. REGISTRAR'S SIGH	TATURE	3									



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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within—5 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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		FOR 1 - STATE	STATE OF MARYLAND /	DEPARTMEN	T OF HEALTH AND	MENTAL HYGIEN	_	, , , , , ,		
Г		1. DECEDENT'S NAME (First, Middle, Last)	CE	RTIFICAT	E OF DEATH	REG. NO.				
			VTON			2. DATE OF DEATH MONTH DA		3. TIME OF DEATH		
			SEX 6. AGE (In yrg. lest	history of an armon		MAY O	1 199:	7 11001		
		7/2 24 210	W M 2 - F 77	YRS. IF UNDE	R 1 YEAR IF UNDER 24 HRS.  DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign		
- 1		Se. FACILITY NAME (If not institution, give stree	t and number)	9b. CIT	Y, TOWN OR LOCATION OF D	EATH TI	9c. COUNTY	OF DEATH		
	OB	Dinai Hospi	tal	E	Baltimor	e.	N	7 <del>A</del>		
	<u> </u>	10g. STATE 10b. COUNTY		10c, CITY_TOWH	OR LOCATION			10d. INSIDE CITY		
	DIRECTO	Maryland NI	A	Ba	fimore.			LIMITS?		
	AL	10e. STREET AND NUMBER	1 1		101. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?		
	FUNERAL	11/19 Beauto	rt Avenu		121215		l U	SA		
		11. MARITAL STATUS  1 Never Married 2 Married	P. WAS DECEDENT EVER IN U.S. ARI		WAS DECENDENT OF HISPAI If yes, specify Cultur, Mexico	NIC ORIGIN? (Specify Yes	or No- 14.	RACE — American Indien, Black, White, etc.		
	B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR OATES		1 YES 2 NO Specif		1	2º CK		
	9	15. DECEDENT'S EDUCAT (Specify only highest grade cor		CEDENT'S USUAL O	CCUPATION	16b. KIND OF BUS	INESS/INDUST	TY		
				Do NOT use retired.)	during most of working	T	1/	1		
83	COMPLET	CT EXTLICITION ANAME OF A ANAME AND A	0 11	UCK	Driver	1/1	<u> </u>	ing		
75	CC	17. FATHER'S NAME (First, Middle, Last)	ntan		18. MOTHER'S NA	ME (First, Middle, Maiden	Surpame)	140		
Pe	20	19g, INFORMANT'S NAME (Type/Print)	1 196	. MAILING ADDRES	S (Street end Number or Rural	Boute Number, City or Town	State Zin Car	ari		
100	2	Eugenia Air	nton 14	719 Be	autort /	ve. Ba	Ho. N	11.21215		
medical examiner must be notified		20e. METHOD OF DISPOSITION 1 Description   Burlet   2   Cremetton   3   Remova	from State 20b. PLACE	ND DATE OF DISPOS	SITION (Name of	DATE 20c. LO	CATION T City	or Town, State		
E		4 Donation 5 Other (Specify)		DUT	45	3/5/95 B	2/10,	Co.Md.		
in in		A A A A	$\varphi \cup \varphi$	22. T	NAME AND ADDRESS OF FA	USS FU	nera	Home		
- S		Joseph	a. Mus	12 2	222 W.N	orth Ave	Bal	to. Md. 21216		
nedic		23. PART I finter the discusses, or commonly mock, or heart failure. Lis	plications that csused the dat t only one cause on each line.	ath. Do not antar	the mode of dying, suc	h es cardiac or respi	ratory srrest,	Approximate Interval Between		
the		IMMEDIATE CAUSE (Finel disease or condition	MIVALOOSE	۸				6 hours		
other traumatic event, the		dissess or condition								
lc ev	. I		CORONARY					YEARS		
ema ema	TIFICATION	Sequentially list conditions, if any, leading to immediate	OUE TO (OR AS A CONSEO	UENCE OF):		-//30		7077		
Tr.	5	CAUSE (Disease or Injury								
oth		that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEO	UENCE OF):						
9 1		d								
shows any Injury.	À	PART II. Other significant conditions c	ontributing to death but not re	eaulting in the ur	nderlying cause given in	Part I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
E S	MEDICA					1 YES 2	. 1	COMPLETION OF CAUSE OF DEATH?		
how		DID TODA COO LIST CO.						1 TYES 2 NO		
23	AN	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL		F OF DEATH (Check		N Q				
ed, or item 23 s	2	EXAMINER?	OSPITAL:	OTHE	R:					
0		27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME OF	sing Home 5 Residence 28c, INJURY AT	8 U Other (Specify)  28d. DESCRIBE HOW IN	JURY OCCURE	0		
		1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY M	WORK?  1 YES 2 NO					
9 0	s II	3 Suicide S Could not be	28e. PLACE OF INJURY — At hon building, etc. (Specify)	ne, ferm, street, fect	tory, office	281. LOCATION (Street e.	nd Number or R	ural Route Number,		
82		4 Homicide determined				City or Town, State)				
2 2 2	1 13		: To the best of my knowledge, dea							
TANT: If It	5	2 MEOICAL EXAMINER: C	n the basis of examination end/or in	westigation, in my o	pinion, death occured at the	time, data and place, end	f due to the ce	use(e) end menner as stated.		
IMPORTANT: II	u II	296 SIGNATURE AND TITLE OF CERTIFIER	b 0 1	4	29c. LICENSE NUM	-	29d. DATE SIC	ENED (Month, Day, Year)		
₹ 2		Unnie MCKELL IT	.D. Resider	U	A574023	21-CM9841	Ma	4 1,1995		

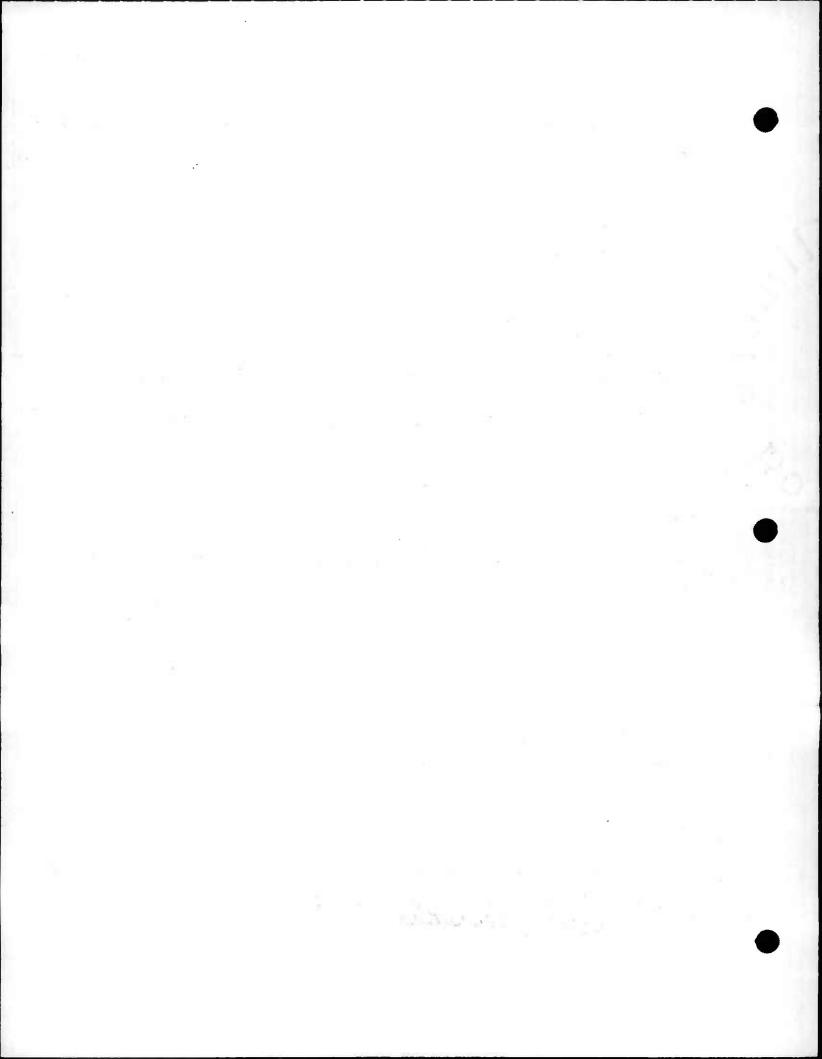
Genie M. Rell M. D. Resident

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

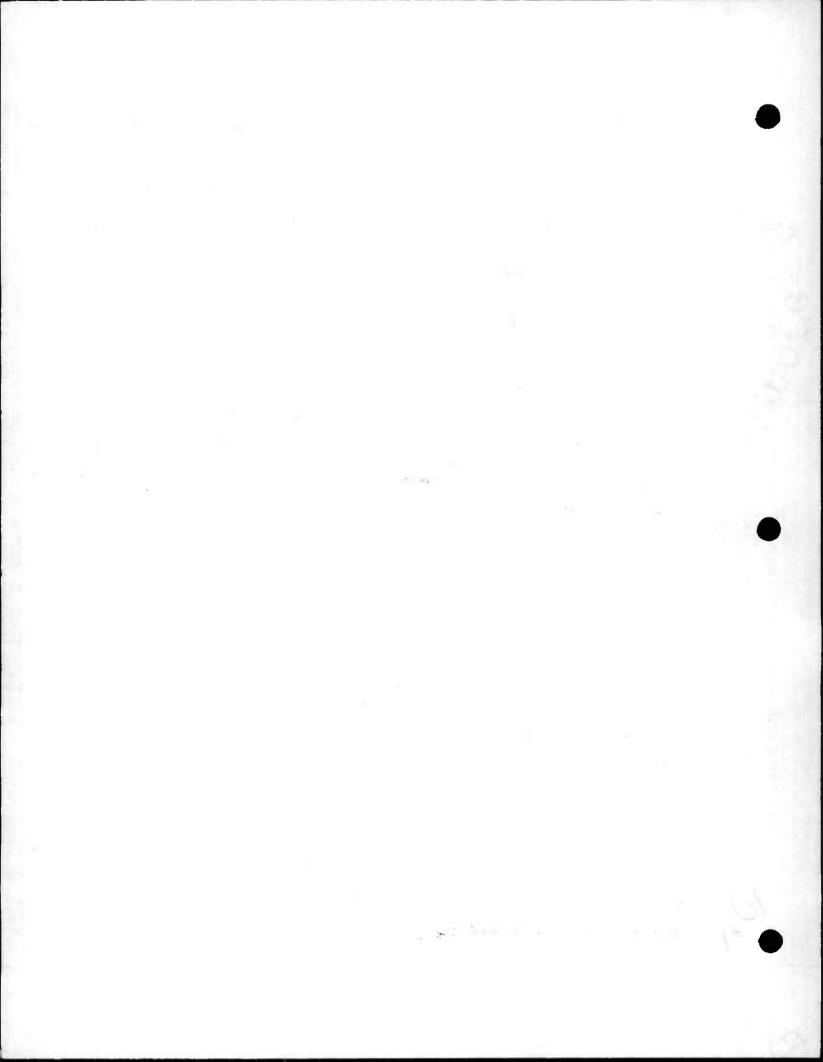
Connie. McR. II M. D. Sinai Hospital

31. DATE FILED (MONTH, Day, Year)

MAY 0 3 1995 Baltimore

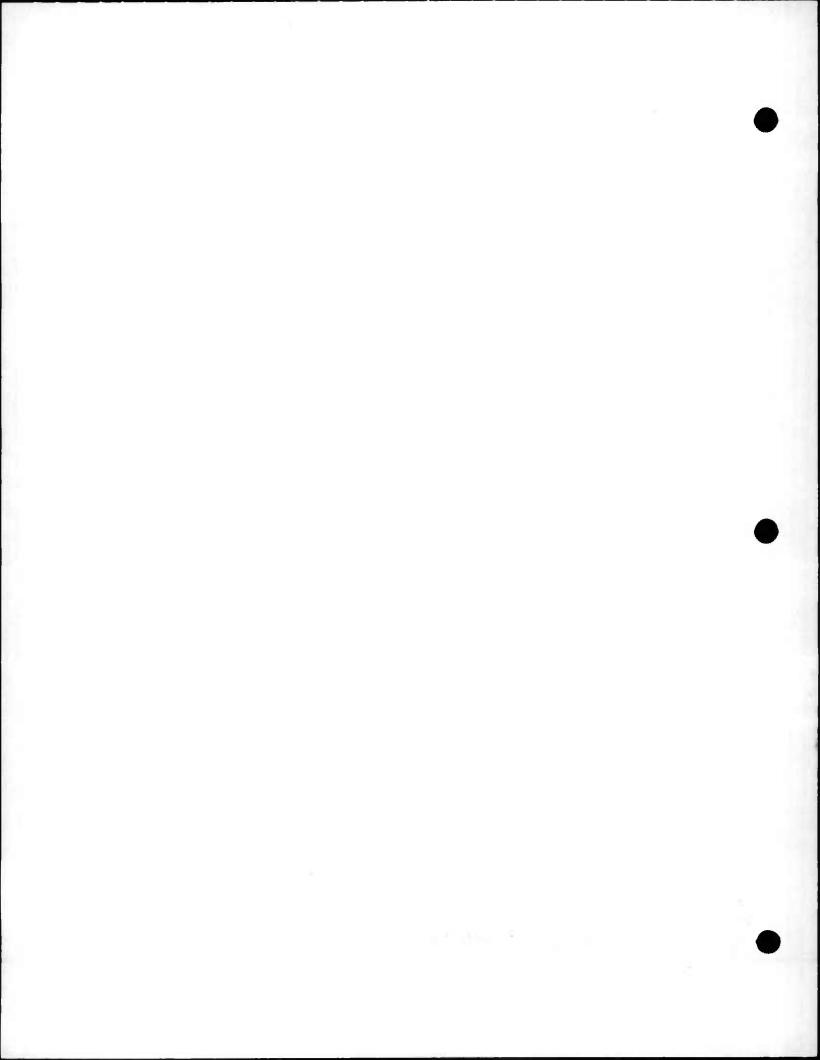


		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	RTMENT OF H	HEALTH AND I	MENTAL HYGIE		
		1. DECEDENT'S NAME (First, Middle, Last)	torn sr				2. DATE OF DEATH MONTH	DAY Y	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER		n yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIFTTH	7 9	5 (: 30 Am
pinous		220-05-8223  90. FACILITY NAME (If not institution, give str	1 M 2 D F 7	3 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) 06 08	21	Maryland
, 2, 3 sho	TOR	Micros Marine	to SpiTAL		GLEN	BURNI			r of death ne Arundel
if. Pages 1	DIRECTOR	10a. STATE 10b. COUNTY	ne Arundel		y, town on Locat denton	TION			10d. INSIDE CITY LIMITS? 1 YES 2 NO
t permit.	3AL	10e. STREET AND NUMBER				. ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?
020 physician. burial-transit	FUNERAL	1883 Betson Ave	12. WAS DECEDENT EVER IN	**6 ********	10 100 050	21113			USA
21215-0020 al or attending physician for use as the burial-trai	₽	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 X YES IF YES, GIVE WAR OR DAT  WWI.	2 NO	If yes, sp	ENDENT OF HISPAN ecify Cuben, Mexica 2 NO Specify	IIC ORIGIN? (Specify Yon, Puerto Ricen, atc.)	ee or No—	R. RACE — American Indian, Black, White, etc. Specify: White
=	品	15. DECEDENT'S EDUC (Specify only highest grade of	:ATION completed)	(Give kind of v	USUAL OCCUPATION		16b. KIND OF B	JSINESS/INDUS	
D 2	PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	Car Ir	nspector		Rail	road	
YLAND 2 by the hospital be detached to at once.	COMPLETED	17. FATHER'S NAME (First, Middle, Last)			Tapa -	18. MOTHER'S NA	ME (First, Middle, Meide		
RYL ed by t	BE	George Washingt	on Horn				argaret Fr		
MARYLAND retained by the hospit s should be detached notified at once.	2	190. INFORMANT'S NAME (Type/Print) Pearl B. Horn					Noute Number, City or To		_
ALTIMORE, death. Page 6 may be the funeral director, page		20s. METHOD OF DISPOSITION	206.1	PLACEANDDATEC	OF DISPOSITION /Na	Ave., Ode	DATE 20c. 1		3 y or Town, State
MOI ige 6 r director		1 N Buriel 2 Cremetich 3 Remort 4 Donation 5 Other (Specify)	Me	eadowric		rial Park	5/1 El	kridge	
BALTIMORE, er death. Page 6 may be the funeral director, page val.		21. SIGNATURE OF EMPERAL SERVICE LICE	ENSEE 1		Gary I	NO ADDRESS OF FAM	CILITY		of Elk., Inc.
	Н	- vary	d. Nough	none	5695 N	Main St.,	Elkridae	. Md.	21227
hin 24 hours tely filled in the mation, or real		23. PART I. Enter the disease or creation of the shock, or heart source. L. IMMEDIATE CAUSE (Final disease or condition resulting in death)	squamus	CE (Î	ung Coi	CiNM G		piratory arrea	t, Approximate interval Between Onset and Death
N 2 5 3 6	_		ECHANICAL			o MEMO	therap.		
	ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A C	CONSEQUENCE OF	Dr. Word	O ( Meina	31110119		
P.O. BOX th certificate be e ending physician Hygiene prior to or other traum	CA	cause. Enter UNDERLYING CAUSE (Disease or Injury		DUE TO (OR AS A CONSEQUENCE OF):					
그 의 한국 노	RTIF	that initiated events reaulting in death) LAST	DOE TO THE MAY A	CONSEQUENCE OF	7):				
S, dea dea le att	0	PART ii. Other significent conditions	contributing to death hu	* net requiting i	- Abo sandaghdas	alum in	I		T
R at the and and in it	MEDICAL	PART II. Otter significant continuous	contributing to destri bui	t not resulting i	n the underlying	g cause given in	Part I. 24s. WAS AI PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
St. of and and and and and and and and and and		DID TOBACCO USE CONTR	IRLITE TO CAUSE OF	DEATH YE	C DENO F	UNCERTAIN			1 TES 2 NO
	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	26	6. PLACE OF DEAT	TH (Check only one)	DIACEKIAN	<u>Ч Ш ]</u>		
CIAN: The Sertificate I the State	YSIC	1 TYES 2 NO	HOSPITAL:  1 Discontinuo 2   ER/Output			e 5 🗆 Residence	8 ☐ Other (Specify)		
O 동 함 환		27. MANNER OF DEATH  1 X Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME	URY WO	RK?	28d. DESCRIBE HOW	INJURY OCCUP	RED
SION TENDING F OR: After to death its is mar	D BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY —	- At home, ferm, a		/ES 2 NO	26f. LOCATION (Street	and Number or	Rurel Route Number,
DIVISION OR ATTENDING DIRECTOR: After hours after death	W .	4 Homicide determined	building, etc. (Specify	ν)			City or Town, State		STEWNS LOS
로 크 오 노	COMPLET		IAN: To the best of my knowled						
HOSPITAL FUNERAL within 72 TANT: 11		2 MEDICAL EXAMINER  296 SIGNATURE AND TITLE OF CERTIFIER	On the basis of examination of	end/or investigation	n, in my opinion, de		Law and		ause(e) end manner ee stated.
TO THE HOSPIT TO THE FUNERA be filed within 7	BE	290 SIGNATURE AND TITLE OF CERTIFIER	MD.			29c LICENSE NUM	BER ( )	29d. DATE S	IGNED (Month, Day, Year)
/>	2	ME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEAT		A 1 1	ital H	huse off	CCI	12/1/3
		31. DATE FILED (Month, Dey, Year)	32. REGISTRAR'S SIGNAT		uc1 (103)	7(101,	10131	( )	
7-/		MAY 0 3 1995 Auto	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	~					



DIVISION OF VITAL RECORDS, P.O. BOX 68/60	BALTIMORE, MARYLAND 21215-0020
TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-24 hours after death. Page 6 may be retained by the hospital or attending physician.	ar death, Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	he funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should ral.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	i examiner must be notified at once.

	505						95	13304	
	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG, NO.								
	1. DECEDENT'S NAME (First, Middle, Last)	hon!	Waston	2		2. DATE OF DEATH MONTH DA	AY CON YEAR	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER		GE (In yrs. lest birthdey)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Your)	6. Bri	RTHPLACE (State or Foreign	
	237-52-7491  9e. FACILITY NAME (If not institution, give at	WAM 2 F 39 YRS.				JUL.30, 1935   RALEIGH, NC			
TOR	Union Memorial Hospital Baltimore City					ty	n/a		
DIRECTOR	RESIDENCE OF DECEDENT  10e. STATE  10b. COUNTY  10c. CITY, TOWN OR LOCATION  MAD DVI AND				0		10d. INSIDE CITY VLIMITS?		
	MARYLAND n/a BALTIMORE  100. STREET AND NUMBER  100. STREET AND NUMBER						1 YES 2 NO		
FUNERAL	1604 NORTHGATE	ROAD			2121		UNITED		
B₹	11. MARITAL STATUS 1 Never Married 2 XX Married 3 Widowed 4 Divorced	R IN U.S. ARMED ES 2 NO R DATES	ED  13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify if yes, specify Cuben, Maxican, Puerto Rican, atc.)  1 VES 2 NO Specify:			fee or No— 14. RACE — American Indian, Black, White, etc. Specify: BLACK			
150	15. DECEDENT'S EDUC (Specify only highest grade of	completed)	16a. DECEDENT'S U (Give kind of wo life. Do NOT use	JSUAL OCCUPATION ork done during most	of working	16b. KIND OF BUS	SINESS/INDUSTRY	1	
COMPLETED	12 TH CABIN SERVICEMAN UNITED AIRLINES						ES		
BE CO	ZELMA RICHARDSON					DSON			
5	190. INFORMANT'S NAME (Type/Print)  MABLE HORTON  180. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)  1604 NORTHGATE ROAD, BALTIMORE, MARYLAND 2121						YLAND 21218		
	20a. METHOD OF DISPOSITION  XX Surial 2 Cremetton 3 Removal from State  20b. PLACE AND DATE OF DISPOSITION (Name of Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of the Completely Francisco of th								
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  WM. C. MARCH FH1101 E. NORTH A								
	23. PART I. Enter the diseases, or canonical series. L	omplications that cause of	od the death. Do no each line.	ot enter the mode	of dying, such	n aa cerdiec or respi	ratory arrest,	Approximate interval Between	
	IMMEDIATE CAUSE (Finel disease or condition reaulting in death)  a. Cerebral Vascular Accident amonths								
	DUE TO (OR AS A CONSEQUENCE OF):								
TION	Sequantially list conditions,  If any, laeding to immediate  DUE TO (OR AS A CONSEQUENCE OF):							IU KEARS	
FICA	Sequentially liet conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b.								
ERTI	reaulting in death) LAST								
. 1	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED?  AMILABLE PRIOR TO								
MEDICAL	111010715 111011111111111111111111111111					1 _ YES 2		COMPLETION OF CAUSE OF DEATH?	
N.	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN X								
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1 VES 2 NO  28. PLACE OF DEATH (Check only one)  OTHER:  OTHER:  1 Vinpatient 2 ER/Outpatient 3 DOA  4 Nursing Home 5 Residence 8 Other (Specify)								
PHY	27. MANNER OF DEATH	28a. DATE OF INJUR (Month, Day, Year	Y 28b. TIME	OF 28c. INJUF	Y AT	8 ☐ Other (Specify)  28d. DESCRIBE HOW II	NJURY OCCURED		
BY	1 Natural 5 Pending Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJU	RY — At home, farm, str		8 2 NO	28f. LOCATION (Street a	and Number or Burn	al Brusta Number	
ETED	4 Homicide determined	uid not be building, atc. (Specify)						, vecto realizad,	
COMPLET	29s. CERTIFIER (Check only one)  2  MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.  MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.								
BE	206. SIGNATURE AND THE CONCERTURER HO PEY-1				29c. LICENSE NUMBER  AT 2438946  29d. DATE SIGNED (Month, Day, Year)  APRIL 30, 19			ED (Month, Day, Year) 11 30, 1995	
10	30. NAME AND ADDRESS OF PERSON WHO	OSPITAL							
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE								
MAY v 3 1995 jave develor Radall									



DHMH-16 Rev 1/89

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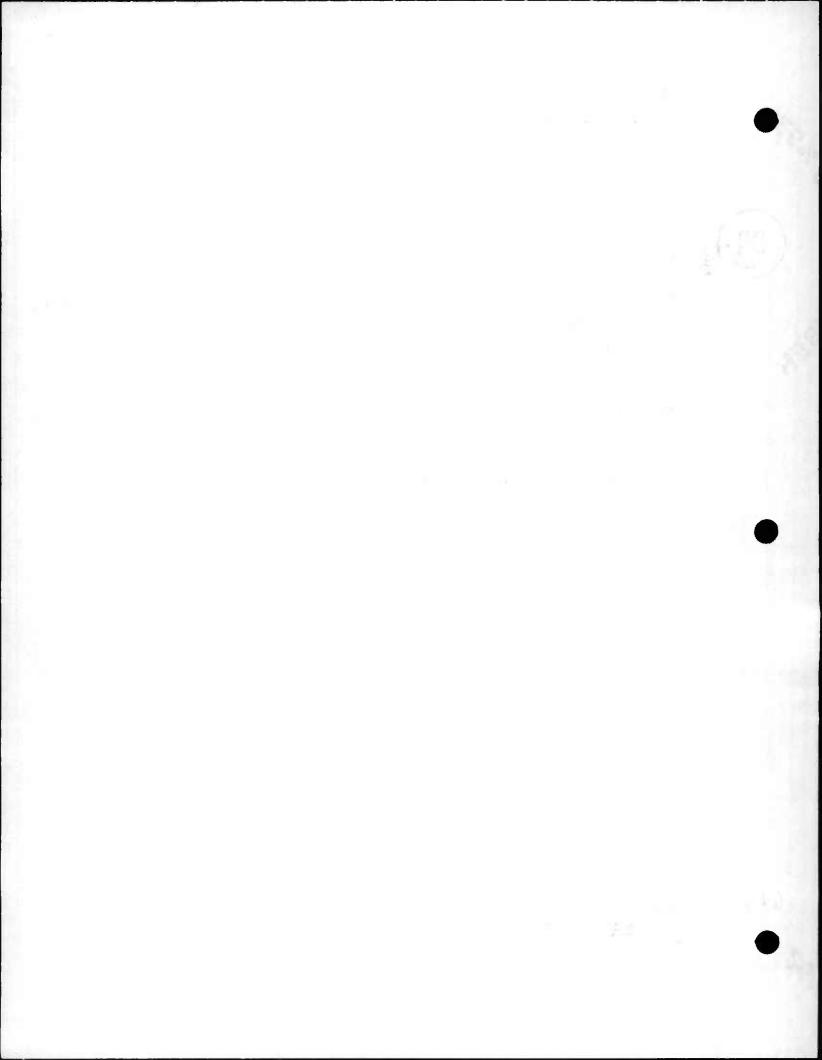
TO THE MOSPITAL OR ATTROUNG PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should have after clearly with the State Deut, of Health and Mental Horieve ning to have after clearly with the State Deut.	IPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR AT	TO THE FUNERAL DIRECT De filed within 72 hours	IMPORTANT: If Item

											9	5	3305
	1 - FOR STATE REGISTRAR	STATE OF MA					IEALTH DEAT		MENTA	L HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)									OF DEATH	2	-25	3. TIME OF DEATH
	Martha	I	Hopewel	1					Apr		7.	1995	3145 a, M
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. las		IF UND	ER 1 YEAR	IF UNDER	24 HRS.	2 DATE	OF BIOTH			HPLACE (State or Foreign
	212-44-9656	1 🗆 M 2 💢 F	50	YRS,	MONTHS	DAYS	HOURS	MIN.	(Mont	.29,19	1/1	Count	ry)
	9a. FACILITY NAME (If not institution, give str	met and number)	30		01-00	TOWN TOWN	OR LOCATIO			.29,13			yland
œ	1329 W. North Ave		Floor					ON OF DE	HTA		9c. CO	UNTY OF E	
0	RESIDENCE OF DECEDENT	riue zna	FIOOL		В	alti	liore					n	/a
DIRECTOR	10a. STATE 10b. COUNTY			L soc CIT	V TOWN	OR LOCA	FION						Service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and the service and th
<u>~</u>	MD	n/a				imor							10d. INSIDE CITY LIMITS?
		11/ a		Г,	Dail								1 X YES 2 NO
¥	10e. STREET AND NUMBER					10	. ZIP CODE				,		WHAT COUNTRY?
BY FUNERAL	1329 W. North Ave	enue 2nd	d Floor				2121	L7			ט	.S.A.	
5	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. AR	MED	13	. WAS DEC	ENDENT O	F HISPAN	IIC ORIGII	17 (Specify Ye	or No-	14. RAC	E — American Indian, k, Whita, etc.
7	1 Never Married 2 Married	FORCES? 1 [ IF YES, GIVE WA	R OR DATES	10			ecify Cuba			Rican, etc.)		Spec	
	3 Wildowed 4 Divorced						- M	opoony	•			Spec	Black
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	Ralph Robinson								Norr:		Sumeme)		
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	20a. METHOD OF DISPOSITION 1 🗓 Murial 2 🗆 Cremation 3 🗆 Remo	val from State	20b. PLACE A cemetery, cre				ime of		DAT	E 20c. LO	CATION -	- City or To	own, Slate
- 1	4 Donation 5 Other (Specify)	_//		ZIÓN	CE	METE	RY		5-2	LA	NSDC	WME,	MARYLAND
- 1	21. SIGNATURE OF FUNERIAL SERVICE LICE	IMBEE /	•				ND ADDRES			- D4-			
- 9	►1/60 L. E	4/	1.11							e East			MD 01000
	22 PART I FOR IS	LUNC	W										MD 21202
	23. PART I Entay the diseases, or co	omplications that data	ceused tha de e on each line	ath. Do i	not enta	r the mo	de of dyi	ng, auch	as cere	liac or reap	ratory a	rreat,	Approximate Interval Between
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2	<b>6</b> b	En	112	16.	CK	mello	mys	20-2	the				1 Yearn
CERTIFICATION	Sequantistly list conditions, if any, leading to immediate	DUE TO (C	OR AS A CONSEC	NUENCE O	F):			<u>'</u>	- 1				1 1
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Ĕ	CAUSE (Disesse or Injury that initiated avante	DUE TO (O	OR AS A CONSEC	WENCE OF	F):								1
E	resulting in death) LAST												
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ا ہے	PART II. Other algnificant conditions			eaulting	In the u	ndarlying	g cause g	iven in l	Part i.	24a. WAS AN		24b	WERE AUTOPSY FINDINGS
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		(							-	1 TYES 2	300		OF DEATH?
PHYSICIAN: MEDICAL	DID TORACCO LISE CONTR	IDLITE TO CALL	CE OF DEA	TII VE	·	NO F	1 11110						1 YES 2 NO
Z	DID TOBACCO USE CONTR	IBUTE TO CAU					UNC	ERTAIN	V L				
o l	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEAT	OTHE								
ΥS		1 Inpetiant 2 I E	ER/Outpatient 3	□ DOA			o 5 🖪 Ret	sidence	6 🗆 Othe	r (Specify)			
표	27. MANNER OF DEATH	28a, DATE OF IN (Month, Day,		26b. TIM	E OF URY	28c. INJ WO	URY AT		28d. DES	CRIBE HOW I	NJURY O	CURED	
B	1 Accident S Pending 2 Accident Investigation				M		res 2	NO					
	3 Suicide 6 Could not be	26a. PLACE OF	INJURY - Al ho	ne, ferm, s	treet, fac	ctory, office	•		26f. LOC	ATION (Street :	and Numbe	or Or Rural F	Poute Number,
	4 Homicide datarmined	building, at	w (opecity)						City	or Town, State)			
COMPLETED	29a. CERTIFIER					no de		7.22					
MP	(Check only one) 2 MEDICAL EXAMINED												
8	2   MEDICAL EXAMINER	On the basis of axa	mination and/or i	nvestigatio	n, In my	opinion, d	eath occur	ed at the	lime, date	and place, an	d dua lo l	he cause(a	) and menner as stated.
BE C	296. SIGNATURE AND TITLE OF CERTIFIER				***		29c. LICE	NSE NUM	BER		29d. DA	TE SIGNED	(Month, Day, Year)
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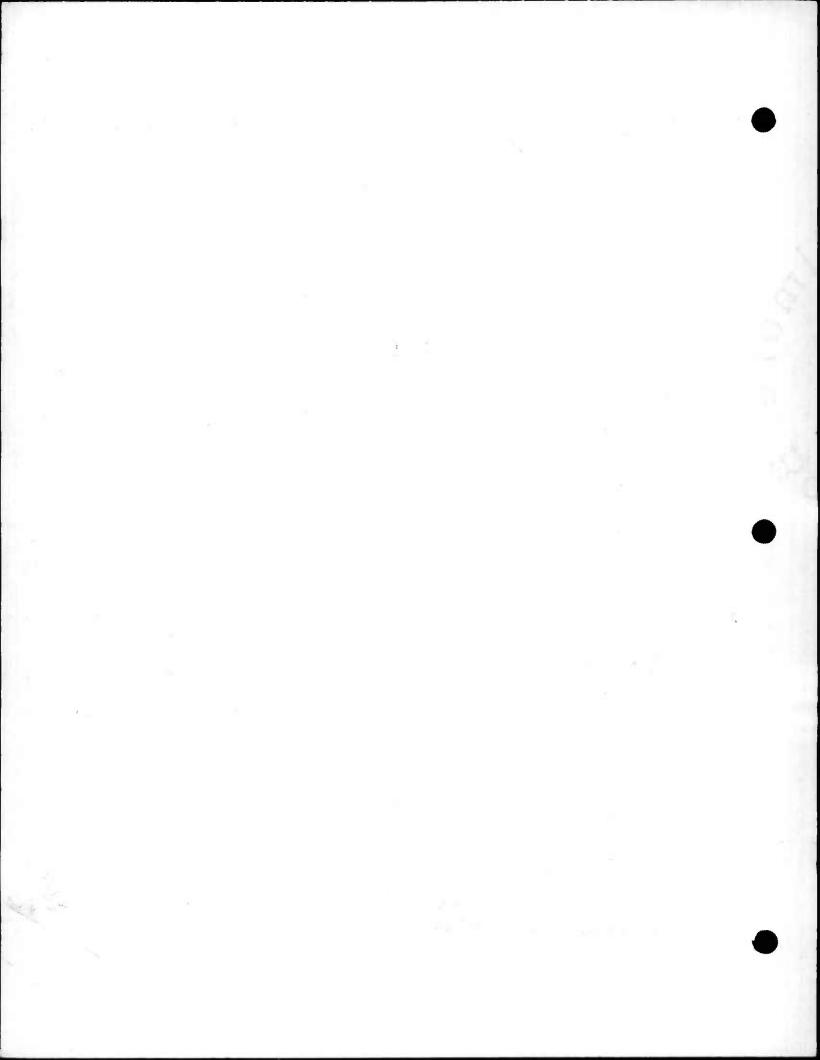
1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Las 2. DATE OF DEATH 3. TIME OF OEATH 04 Christopher Johnson 4. SOCIAL SECURITY NUMBER 5 SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign -241 1 1 2 | F MAR. 9e. FACILITY NAME III not institu TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DINA N RESIDENCE OF EDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 大 Sa ltimore YES 2 NO 10e. STREET AND NUMBE 10f. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? oland 51512 (LSA (1910 12. WAS DECEDENT SYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yee or NoIf yes, specify Cuben, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. Never Married 2 Married Bla Specify: Widowed 4 Divorced 15. OECEDENT'S EDUCATION 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade entery/Secondary (0-12) 1-4 or 5+1 10th Steelworker (A 18 MOTHER'S NAME (First, 17. FATHER'S NAME (First, Middle, Last) 75 own notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (St Hd MARGUORIte Edward 21215 421 Pe METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -, City or Town, State must OATE Burlel 2 Cremation 3 R tion 8 Other (Specify) em -9 examiner RE OF FUNERAL SERVICE LICENSEE ADDRESS OF FACILITY -WEST BALTO. HOME 4300 WABASH AVE. 21215 MD event, the medical Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cerdiac or reapiratory arrest, shock, or heart feliure. List only one ceuse on each line. 23. PART I. Enter the Approximats Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) Librillation Undonn Zeh DUE TO (OR AS A CONSEQUENCE OF): traumatic Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If sny, lesding to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury other CERTIFIC that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in desth) LAST Injury, or PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any 1 - YES 2 - NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item HOSPITAL:
1 | Inpatient 2 | EN/Outpatient 3 | DOA OTHER: 1 YES 2 NO 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED marked. 1 Natural 5 Pending Investigation BY 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, ferm, streef, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 60 ETED. 8 Could not be 4 Homicide 28 item COMPL CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end manner se stated. (Check only one) TO THE HOSPITAL TO THE FUNERAL (
be filed within 72 h
IMPORTANT: If it 2 MEDICAL EXAMINER: On ation end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end manner se stated. SHATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE 2 OF DEATH (ITEM 27) (Type, Print) LATHOLUNUS MO21023 Rn 32. REGISTRAPES SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within frours after death. Page 6 may be retained by the hospital or attending physician.		be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.	
PHYSICIAN:	this certifica	with the St	
TENDING	IRECTOR: After	after death	
AL DR AT	IL DIRECT	2 hours	
HOSPITA	HE FUNERA	within 7.	-
TO THE	THE THE	be filed	The same of the same of the same

			20	10001
	1 - STATE STATE STATE OF MARYLAND / DEPARTMENT			
	REGISTRAR CERTIFICATE  1. DECEDENT'S NAME (First, Middle, Last)		REG. NO.	
	John L. Leary	2. DAT		7EAR 3. TIME OF OEATH
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 11	// //	E OF BIRTH 8.	BIRTHPLACE (State or Foreign Country)
- {	273-05-358 / 124 2 90 YRS.		mu 3.905	Martyoung
	9a. FACILITY NAME (If not institution, give street and number)  9b. CITY, TO	OWN OR LOCATION OF DEATH		Y OF DEATH
2	3 mai Hospital Ba	timore,	MD Bal	Howe City
<u>ျ</u>	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY 10c. CITY, TOWN OR	OCATION		10d. INSIDE CITY
DIRECTOR	Md Not Baltimor			LIMITS?
	100. STREET AND NUMBER	10f. ZIP CODE	the CITIZE	1 YES 2 NO
FUNERAL	2401 St Stanhens Court	21216	(1	15.4
1 5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ABMED 13. WA	B DECENDENT OF HISPANIC ORIG	iiN? (Specify Yes or No.— 14	J. RACE — American Indian.
BY F	t Never Married 2 Married FORCES? 1 YES 2 NO It y 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES	Pe, specify Cuban, Maxican, Puert YES 2 NO Specify:	o Rican, etc.)	Black, White, atc. Specify: 2 / /a
	S WOMEN 4 DIVORCES	7		place
E	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  16e. DECEDENT'S USUAL OCCI (Give kind of work done duri	JPATION 10 10 10 10 10 10 10 10 10 10 10 10 10	Bb. KIND OF BUSINESS/INDUS	ebrun Baptist
片	Binnertary Secondary (0-12) College (1-4 or 5+) Pas + +97		New MI H	euron saprisi
once.	17. FATHER'S NAME (First, Middle, Last)	46 MOTUEPIO MANE (C)	charev	~
2 0	Nach Leury	16. MOTHER'S NAME (First	, MIGGIe, Maiden Surname)	
BE BE	19e. INFORMANT'S NAME (Type/Print)	treet and Number or Rural Route Nu	mber Chr. or Trum Chr. 71- Cr	
5	Earline D. Loury 2401 St	Start . C	+ 0 11.	ul 21216
8	20a. METHOD OF DISPOSITION 20b. PLACEAND DATE OF DISPOSITION		TE 20g. LOCATION - CIT	V
E	1   Buriel 2   Cremation 3   Removal from State   Cemergly, spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Cemergly spensory brottler (Specify)   Ceme	11 // / / /-/	45 haunel	11/
è		ME AND ADDRESS OF FACILITY	Tung 4,	MO
examiner must be notified at once.  TO BE COM	▶ 800 a significant later	ich F. H. Wast		Are Balk nd
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the	436	10 Walusto	the Balk my
medical	anock, or neart failure. List only one cause on each line.	mode of dying, such as ca	rdiac or reapiratory stres	t, Approximate Interval Between
<b>a</b>	IMMEDIATE CAUSE (Final disease or condition			Onset and Death
ent,	resulting in death)  a. DUE TO (OR AS A CONSEQUENCE OF):	eunonei		10dys
or other traumatic event,	= stmkp			1 4
r other traumatic	Sequentially list conditions, If any, leading to immediate  DUE TO (OR AS A CONSEQUENCE OF):			1 month
<b>E E</b>	cause. Enter UNDERLYING CAUSE (Disease or Injury			
	that initiated eventa DUE TO (OR AS A CONSEQUENCE OF):			T#
9 1	resulting in desth) LAST			
Injury,	PART II. Other algorificant conditions contributing to death but not resulting in the unde	riving cause given in Part I.	24s. WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
	HTM, CAD. Pernicurio Aven	A CA	PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
shows any : MEDIC			1 UYES 2 THO	OF DEATH?
Show Show	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO	UNCERTAIN D		1 TYES 2 NO
1 23 s	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only			
SICI/	EXAMINER? HOSPITAL: OTHER:	Home 5 Residence 6 Ott	10-raths	
<u>∘</u>   ≥	27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28		ner (Specify) EŞCRIBE HOW INJURY OCCUR	RED
A P	1 Netural 5 Pending (Month, Day, Year) INJURY Accident Investigation	WORK?  YES 2 NO		
Is mar	2 Accident Investigation 3 Suicide 6 Could not be 28e. PLACE OF INJURY — At home, farm, street, tectory, building, stc. (Specify)	office 28f. LO	CATION (Street and Number or	Rural Route Number,
28 TE	4 Homicide datarmined	CH	y or Town, State)	
MPLET	29a. CERTIFIER (Check only CERTIFYINO PHYSICIAN: To the best of my knowledge, desth occurred at the time	data and place, and due to the o	suse(s) and manner as stated	
W C	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opin			ause(s) and manner as stated.
IMPORTANT: If Item 28 is marked, O BE COMPLETED BY PH	29b/SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER 1		IGNED (Month, Day, Year)
APOR H	Vascle	1524073	- 16 17	
우	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	MJ LIV L	- An	W 30 , 1775
	Vincent Cee / Sinai Hospital 240	1 W. B	edese, Balt	41215
	31. DATE FILED (Month, Day, Year)  32. REGISTRAT'S STONATURE  MAY 12 2 1995  July dawners	W. Jeal	were, Day	1000 190
	MAY U 3 1995 July d'Avaler tartell			



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DIVISION OF VITAL RECORDS, P.O. BOX 68760	NING.	2444
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	OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may b	INEGAL DISCOURT this conditions has been signed by the attending shadown and completely filled in his she funded discourse and
	SS	IAIR

COMPLETED

BE

2

4 Homicide

(Check only one)

29b. SIGNATURE AND TITLE OF CERTIFIER

Wild

29e. CERTIFIER

Mark

6 Could not be

determined

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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V: The la	State Dep	Item 23
HYSICIA	his certifi with the	ked, or
NDING P	R: After t er death	is mar
OR ATTE	DIRECTO	tern 28
OSPITAL	UNERAL ithin 72 I	ANT: It I
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 13308 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY VEAD MARGARET LORAH 28 1995 April 4:30 AM 4. SOCIAL SECURITY NUMBER 7. DATE OF BIFTH (Month, Day, Year) Aug. 27, 1895 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPI ACE (State or Fornice 218-28-6916 1 M 2 F 99 Baltimore Co.Md. Se. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Smith's Home for the Elderly Edgewood Harford RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Harford Maryland Joppa 1 YES 2 X NO 10e, STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 902 Fawn Court 21085 USA 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 Married BY Specify 3 🔣 Widowed 4 🔲 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ost of working (Give kind of work done life. Do NOT use retired.) tary/Secondary (0-12) College (1-4 or 5 +) 4 Housewife Homemaker 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First Middle Maiden Sumame) Jacob Neumeister Anna Winterstein BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 9 Wesley Bartenfelder 902 Fawn Court Joppa, Md. 21085 20e. METHOD OF DISPOSITION
1 N Burlel 2 □ Cremation 3 □ Rer 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State val from State St.Michaels Luth.Cem. May 1,1995 ☐ Donation 5 ☐ Other (Specify) Perry Hall, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Richard Hes Eureral Home E. F. Lassahn Funeral Home 11750 Belair Rd. Kingsville, Md. 21087 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final **Onset and Death** Atheroscleratic Cardievescular disease diseese pr condition_ resulting in death) 40915 CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to deeth but not recuiting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO 1 - YES 2 . NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO I UNCERTAIN I PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER:
4 | Nursing Home 5 | Residence 8 (X Other (Specify) 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA Boarding 27. MANNER OF DEATH 28s. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF 28c. INJURY AT 1 Natural
2 Accident 5 Pending 1 YES 2 NO В Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner as stated.

Avenue Bel

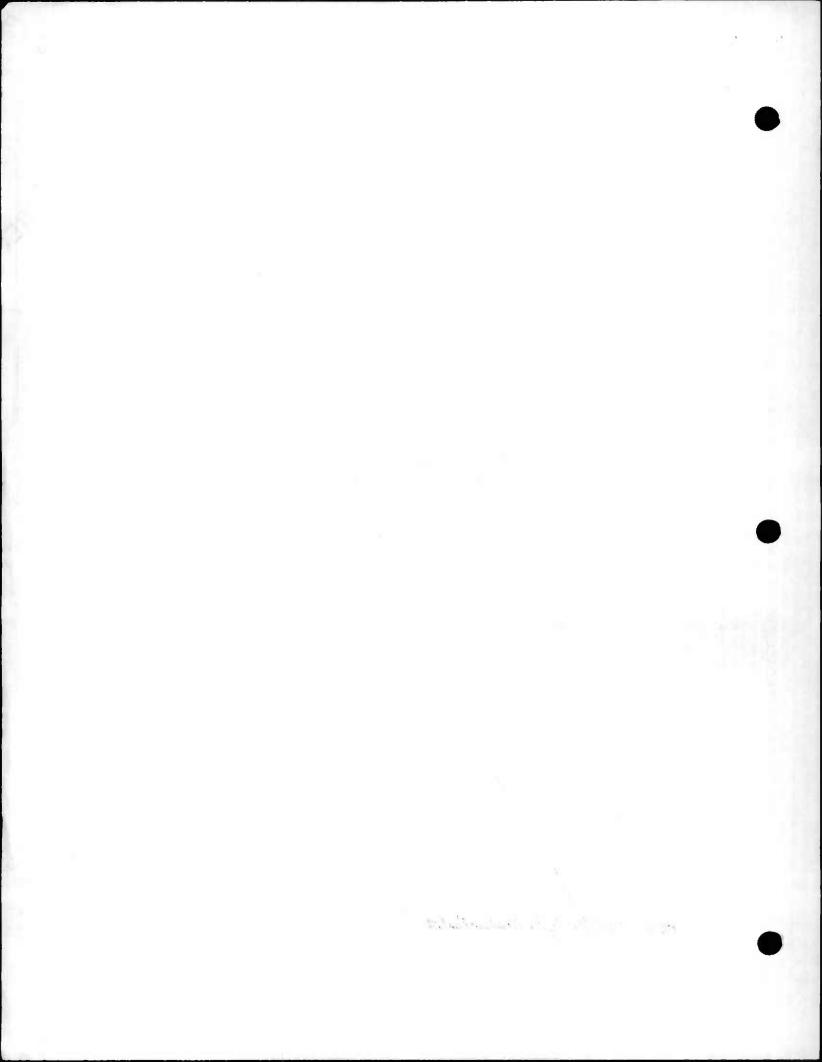
tion and/or investigation, in my opinion, death occured at the lime, date end place, end due to the ceuse(e) end manner as stated.

29c. LICENSE NUMBER

DHMH-16 Rev 1/89

29d. DATE SIGNED (Month, Day, Year) 4-28-9

21014



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

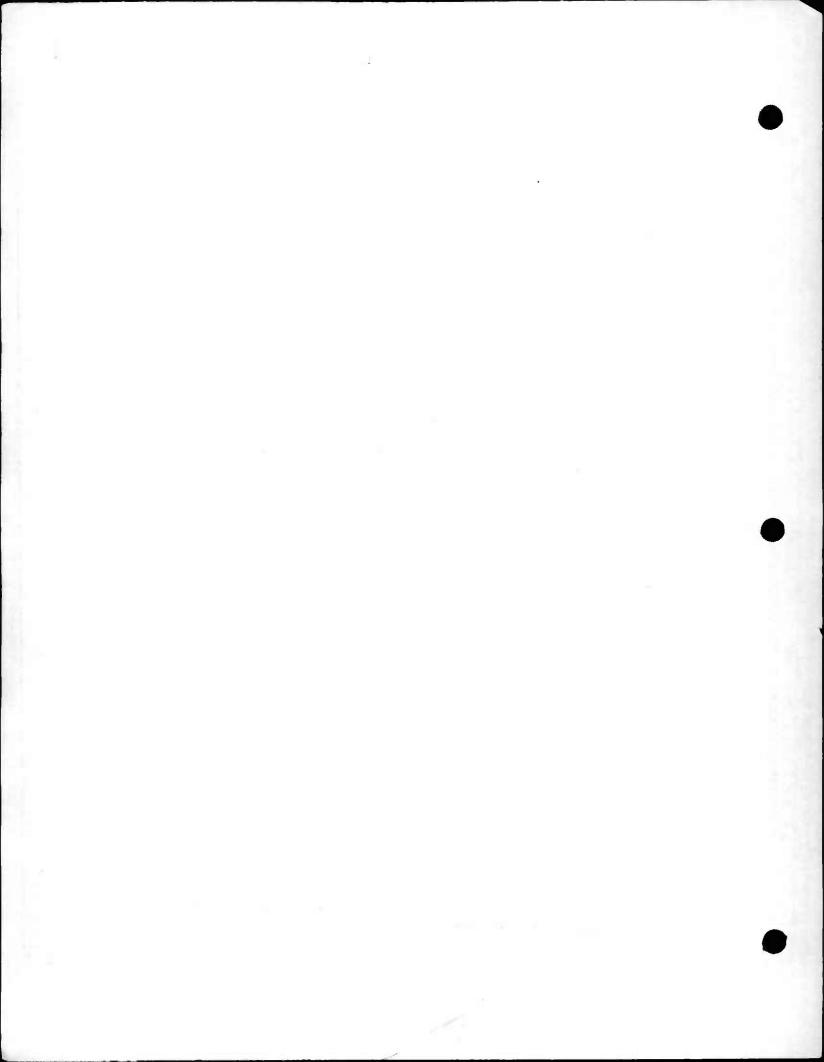
95-		97 ITEMS: 23 PAR	T I, 27,	28a-f, PE	R MEO	FILM	G-72	4 6/30	/95 t	.t	9	5	13309
		FOR 1 - STATE REGISTRAR		ARYLAND	DEPAR	TMEN	IT OF H		AND N	MENTAL HYGII			
		1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH			3. TIME OF DEATH
		BLAIR	LA	MONT		LAN	JE.			04 0	O 1 C	95	1:25 P M
- 1		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la	st birthday)		ER 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH	9 13		PLACE (State or Foreign
		217-92-0383	1 🖾 M 2 🗌 F	25	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year)		Country	1)
		9a. FACILITY NAME (If not institution, give stre	et and number)			9ь. СП	Y. TOWN	OR LOCATIO	ON OF DE	10/10/6		Man	cyland
2	5	8224 BEACH ROAL					ASAD						RUNDEL
Dieceroe		10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN	OR LOCA	TION					10d. INSIDE CITY LIMITS?
		Maryland Anne A	rundel C	0.		P	asad						1 TES 2 NO
	3						10	f. ZIP CODE	E .		10g. CIT	IZEN OF W	HAT COUNTRY?
ü		8277 Edwin Raynor							122			U.S.	Α.
DV ELINEDAL	5	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2	RMED	13	If yes, sp	CENDENT O Healfy Cube 3 2 X NO	n, Mexican	C ORIGIN? (Specify , Puerto Rican, etc.)	Yes or No-	14. RACE Black	- American Indian, White, etc.
C	3	15. DECEDENT'S EDUCA	TION	16a. DE	ECEDENT'S	USUAL	OCCUPATION	ON		16b. KIND OF I	BUSINESS/INI	DUSTRY	
		(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5 +		sive kind of a n. Do NOT us	work done se retired.	during mo	ost of workin	g	1300 1000 010	20011120071111	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
٥		12	1	'   ·	Ba	arbe	r			Pombo	m Cha		
once.	5	17. FATHER'S NAME (First, Middle, Last)				1100	. 1	18. MOTH	ER'S NAM	IE (First, Middle, Maid	r Sho	<u> </u>	
# G		William H. Lane									on domaine)		
20 0	ן מ	19s. INFORMANT'S NAME (Type/Print)		10	h MARING	ADDRES	DC /Ctmat a			Lane Oute Number, City or 1			
1 P	2	William H. Lane											
8		20a. METHOO OF DISPOSITION		20b. PLACE					c RTA	d Pasade			
T S		1   Buriel 2 ☐ Cremation 3 ☐ Remov  Mathematical Buriel 2 ☐ Cremation 3 ☐ Comparison 5 ☐ Other (Specify)	al from State	cemetery, cre	ematory or of	ther place	1			100	LOCATION —		
6	ı	21. SIGNATURE OF FUNERAL MERVICE LICE	NSEE 4	L Moun	t Zic	on C	hurc	h4/16	5/95	Pa	saden	a Mar	yland
examiner must be notified at once.	ĺ	> / 0 C/	1	1		E	step	Bros	s. Fu	inera Hom			
		23. PART . Enter the diseases, or co	mollostions that	M	-A D.		300	Eutav	v Pla	ice Balto	MD :	<u> 21217</u>	
the medical	1	shock, or heart fallure. Li	st only one caus	on each line	eath. Do n	ot ente	r the mo	de of dyl	ng, auch	aa cerdiec or res	spiretory an	reat,	Approximate Interval Between
2	-	iMMEDIATE CAUSE (Fine) disease or condition	DDOMETH										Onset and Death
£.		reaulting in deeth)	DROWNIN	U .	114								
or other traumatic event,		New Years and the second	DUE TO (	OR AS A CONSE	OUENCE OF	ን:							
r other traumatic		Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (	OR AS A CONSEC	OUENCE OF	7:							
를 음		CAUSE (Disease or injury that initiated events	DUE TO (	OR AS A CONSE	OUENCE OF	٦٠							
1 E		resulting in death) LAST			OCCIOC OF	,.							
	1 1	d.											-
shows any injury, MEDICAL CI		PART ii. Other aignificent conditions	contributing to	deeth but not r	esuiting i	n the u	nderiyin	g ceuse g	Iven in P	Part I. 24s. WAS	AN AUTOPSY	24b.	WERE AUTOPSY FINDINGS
ws any in										1992	ORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
1 N										- I IXTES	2 NO		OF DEATH?
Show S		DID TOBACCO USE CONTRI	PLITE TO CAL	ISE OF DEA	TU VE	c 🖂	NO F	LING	EDTAIN				1 YES 2 NO
SICIAN:		25. WAS CASE REFERRED TO MEDICAL	BUTE TO CAL					UNC	ERTAIN				
or item		EXAMINER?	HOSPITAL:	Total Control	E OF DEAT	OTHE							
0 >		1 X YES 2 NO 1	Inpetient 2							Other (Specify)		CENE	2
PHY		1 Natural 5 Pending	(Month, Da	y, Year)	FOUND			RK?		26d. DEŞCRIBE HOV		CUREO	
marked, BY PH		2 Accident Investigation	FOUND: 4		1:00	РМ	1 🗆 1		1111	SUBJECT DRO			
m 28 ls ETED		3 Suicide 6 CCOuld not be detarmined	26s. PLACE OF building, a	INJURY At ho itc. (Specify)	me, ferm, s WATER					261. LOCATION (Street City or Town, Sta B224 BEACH	(e)		NA. MD.
티		29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIA	N: To the best of	my knowledne 4s	ath occur-	d at the	time data	and elec-	and due 1	o the ages to be t			
MPORTANT: If Item  O BE COMPLE		(Check only one) 2 MEDICAL EXAMINER:											and menner as stated.
E C		296. SIGNATURE AND TITLE OF CERTIFIER	11 -		-			29c. LICE	NSE NUME	BER	29d. DAT	E SIGNED (	Month, Day, Year)
2   ≥		Theodore Uc	King u	0	_			0.0	.M.	Ε	►AF	RIL	10,1995

31. DATE FILED (Month, Day, Year)
IVIAT V 3 1995

111 Penn Street, Baltimore, Maryland 21201

PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DHMH-16 Rev 1/89



3. TIME OF DEATH

6. BIRTHPLACE (State or Foreign Country) Maryland

Baltimore County

14. RACE — American Indian, Black, White, etc.

10d. INSIDE CITY 1 YES 2 1 NO

12:05

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. hours after death. Page 6 may be retained by the hospital or attending physician. once. notified at must be TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral direbe filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner.

DIRECTOR

FUNERAL

BY

BE COMPLETED

2

PHYSICIAN: MEDICAL CERTIFICATION

ВҰ

COMPLETED

BE 2

1 - STATE REGISTRAR	_	STATE OF I	MARYLAND /				DEATH AN	ID N		GIENE			
1. DECEDENT'S NAME (First,	Middle, Last)								2. DATE OF DEA				3. TIME OF DEAT
Mary	Fra	nces		Mu	th				May	2 DAY	1	995	12:05
4. SOCIAL SECURITY NUMBER	ER	5. SEX	8. AGE (In yrs. las	t birthday)		R 1 YEAR	IF UNDER 24 H	_	7. DATE OF BIRT	TH		6. BIRTH	IPLACE (State or Fo
217-20-2345		1 🗆 M 2 📉 F	82	YRS.	MONTHS	DAYS	HOURS MI		Nov. 14	4.4	912	Mar	vland
9e. FACILITY NAME (If not ins	titution, give s	treet end number)			9b. CIT	Y, TOWN (	OR LOCATION O			1	9c. COU	NTY OF D	
Cardinal St	neehan	Center	for the	Agir	g	To	wson			$\perp$	Ba	ltim	ore Cour
10a. STATE	10b. COUNTY	,		10c. CIT	Y, TOWN	OR LOCAT	TION						10d. INSIDE CITY
Maryland	Balti	more Cou	ntv	To	wson								LIMITS?
10e. STREET AND NUMBER					31001		. ZIP CODE				10g. CIT	IZEN OF Y	VHAT COUNTRY?
2300 Dular	nev Va	llev Roa	d				2120	/,				USA	
11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. AR		13.	WAS DEC	ENDENT OF HI	SPANI	IC ORIGIN? (Spec	Ify Yes o	r No-		- American India
1 Never Married 2   1		FORCES? 1		10		If yes, sp	ecify Cuben, Ma	exicen	, Puarto Rican, el	tc.)		Black Speci	, Whita, atc.
3 Widowed 4 Divon	bec	2 /1/2/1/2014	N. 17					Duciny				Speci	" White
	DENT'S EDUC		16a. DE	CEDENT'S	USUAL O	CCUPATIO	ON st of working		166, KIND (	OF BUSI	NESS/INI	DUSTRY	
Elementary/Secondary (0-	12)	College (1-4 or 5	life	Do NOT u	se retired.)	outing inc	or or working						
			Reg	giste	red	Nurs	se			Med:	ical		
17. FATHER'S NAME (First, Mic	ddle, Last)						18. MOTHER'S	S NAM	AE (First, Middle, N	Aaiden St	umame)		
Edward Sal	bastia	n Muth					Anna	G	ertrude	Arı	nino		
19a. INFORMANT'S NAME (Ty)	pe/Print)		191	b. MAILING	ADDRES	S (Street a			oute Number, City				
Nancy P. I	Burns		1 2	2014	Опач	Vil	1age (	COLI	rt #201				
20s, METHOO OF DISPOSITION 1 X Burlet 2 Cremetton	ON		20b. PLACE	AND DATE	OF DISPOS	SITION /Ne				0c. LOCA	TION —	City or To	wn, State
4 Donation 5 Other	Specify)	oval from State	- New C	matory or o	ther place)	Cem	eterv		5/4 F	3-1+	imo	no 1	Maryland
21. SIGNATURE OF FUNERAL	sember Lic	ENSEE	THEN	acric	22.	NAME AN	D ADDRESS O		ILITY		LIIIO	e, I	aryrand
Marina	700	ICON			M	itch	ell-Wie	ede	efeld Ho	ome			
LIGITOTII	D. Lav	vson							, Balti		e. M	m 21	212
23. PART i. Enter the dis	seasea, Dr c	omplications tha	t caused the de		not enter	tha mo	de of dying,	auch	aa cardiac or	reapire	tory an	reat,	Approxime
IMMEDIATE CAUSE (Fine			יוןיבקיים		180	0/	pik	PE	:				Onset and
disease or condition resulting in death)	<b>&gt;</b>	•	,				/						
rosoning in south,		DUE TO	(OR AS A COMSE	DUENCE O	F):								
ter against the			14/8	2108	1876	22/2							
Sequantially list condition if any, leading to immedicause. Enter UNDERLYIN	late	DUE TO	(OR AS A CONSEC	DUENCE O	F):								

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN

PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i.

DUE TO (OR AS A CONSEQUENCE OF):

24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 | YES 2 | NO

Approximate interval Between Onset and Death

25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one

EXAMINER? HOSPITAL: 1 - YES 2 -40 1 Inpetient 2 EleCut 27, MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 1 Natural 5 Pending

Investigation

6 Could not be

□ DOA 26b. TIME OF INJURY

28c. INJURY AT WORK? 1 YES 2 NO

ng Home 5 - Residence 6 - Other (Specify)

26d. DEŞCRIBE HOW INJURY OCCUREO

261, LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e, CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner es stated.

2 MEDICAL EXAMINER: On Investigation, in my opinion, death occured at the time, date end piece, and due to the ceuse(a) and menner es stated

- All home, farm, street, tectory, offica

29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNEO (Month, Day, Year)

C. NAME AND ADDRESS OF THIS ON WHO COMPLETED CAUSE	OF DEATH (LIEM 27) (Type, Print) (1/12/2)	Villy Red	21206

31. DATE FILED (Month, Day, Year) 1995

CAUSE (Disease or Injury

LAYBRIE

2 Accident

3 Suicide

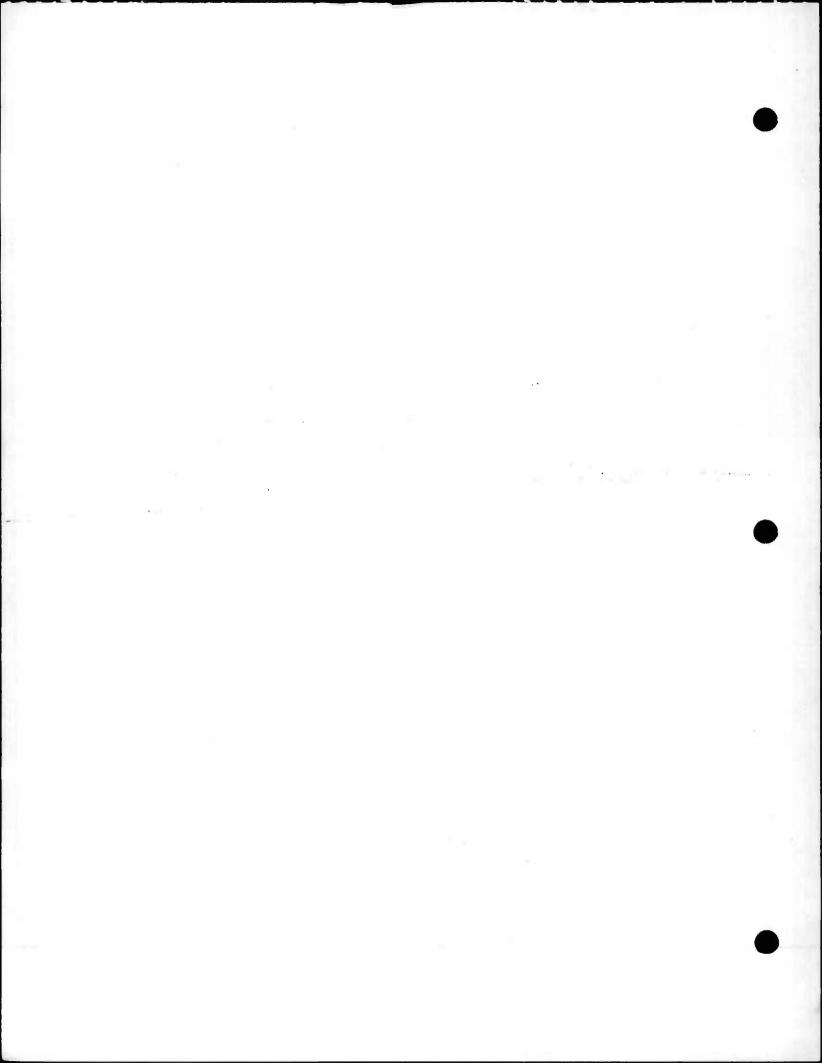
4 Homicide

that initiated eventa resulting in death) LAST

32. REGISTRAR'S SIGNATURE

26e. PLACE OF INJURY

DHMH-16 Rev 1/89



3. TIME OF DEATN

7:03 a

10d. INSIDE CITY

14. RACE — American Indian, Black, White, atc.

Specify: BLACK

HARLEE

XXYES 2 NO

**Onset and Death** 

6 weeks

5 years

10 years

24b, WERE AUTOPSY FINDINGS

1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year) V 5/1/95

AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

8. BIRTHPLACE (State or Foreign

MD

N/A

U.S.A.

REG. NO. 2. DATE OF DEATH

FOR

1 - STATE REGISTRAR

ROBERT

1. DECEDENT'S NAME (First, Middle, Last)

29b. SIGNATURE AND TITES OF CERTIFIER

Daniel 31. DATE FILED (Month, Day, Year)

30. NAME AND ADDRESS CALERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE Davidson Randall

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9	1
DIVISION OF VITAL RECORDS, P.O. BOX 68760	OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate he executed
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	TIGSO

BE

MCCALL MAY 1,1995 4. SOCIAL SECURITY NUMBER 6. AGE (In vrs. lest birthday) 7. DATE OF BIRTN (Month, Day, Year) 9-23-45 IF UNDER 24 HMS. IF UNDER 1 YEAR 212-44-8316 49 1 20 M 2 | F DAYS HOURS YRS 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MD N/A BALTIMORE CITY permit. 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1200 LINDEN LEAF CT. director, page 5 should be detached for use as the burial-transit 21202 your after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 YO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 ND Specify: 1 Never Married 2 X Married IF YES, GIVE WAR OR DATES BY 3 Wildowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) LABORER MONTEBELLO STATE HOSP. 12 N/A 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) JAMES MCCALL notified at LURETHA 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 JAMES MCCALL 1200 LINDEN LEAF CT. BALTO, MD. 21202 è 20s. METHOD OF DISPOSITION
1 See Burlal 2 Cremetion 2 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State I STEEL MT'. ZION CEMETERY \$/5 LANSDOWNE, MD. 22. NAME AND ADDRESS OF FACILITY BETTS FUNERAL HOEM examiner 21. SIGNATURA OF FUNERAL SERVICE LICENSEE 1129 N. CAROLINE ST. BALTO, MD21213 filled in by the medical 23. PART I Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. cremation, or IMMEDIATE CAUSE (Final 4 disease or condition Congestive heart failure resulting in death) or other traumatic event. DUE TO (OR AS A CONSEQUENCE OF) and com bunial, Coronary altery CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to if any, leading to immediate cause. Enter UNDERLYING tobacco use CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST mellitus diabetes the atten Mental H shows any injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? and a drug intraversous signed by Health ar USE 1 TES 2 NO t, of ! DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h **EXAMINER?** HOSPITAL: OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 TES 2 NO 1 Competient 2 ER/Outpetient 3 DOA DIRECTOR: After this cert hours after death with the Item 28 is marked, o 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigation 3 Suicide 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Yown, State) COMPLETED 8 Could not be 4 Homicide determined TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT DE filed within 72 hours a IMPORTANT: If Item 2 29a. CERTIFIER
(Check only one)
One)
One)

MEDICAL SYMMERS On the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

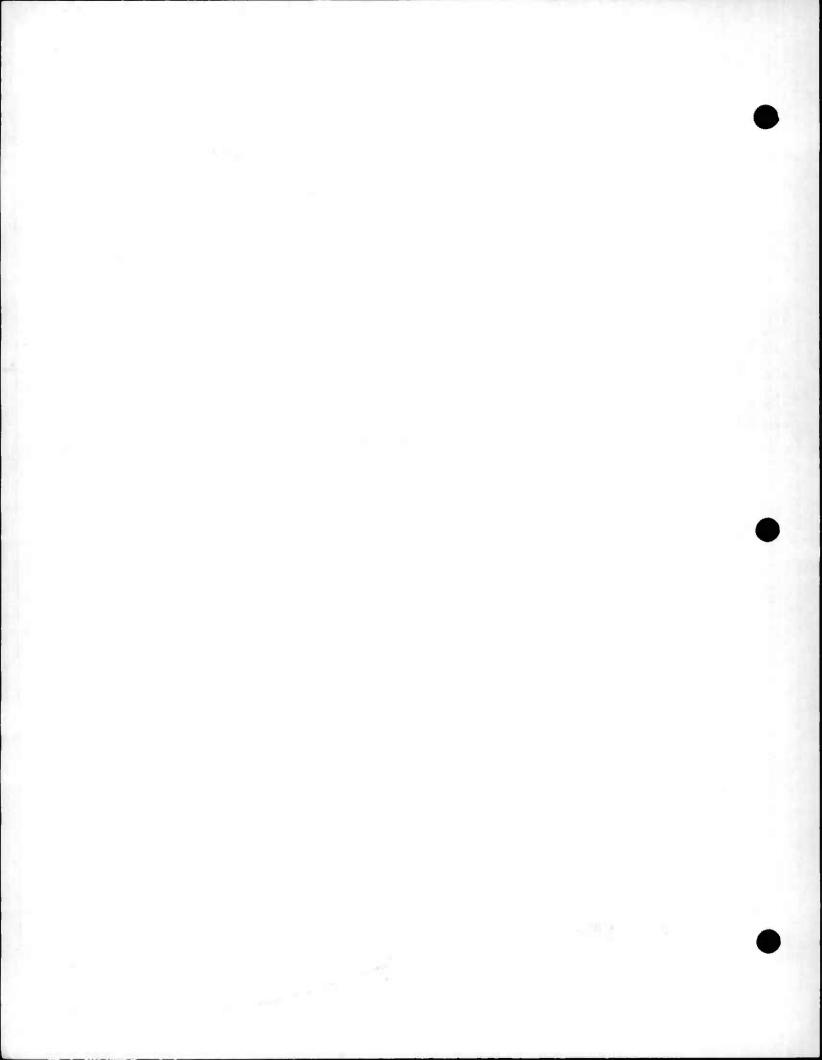
CERTIFICATE OF DEATH

29c. LICENSE NUMBER

P. Judge, MD - Johns Hopkans Hospital

69711

DHMH-18 Rev 1/89



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DIVISION OF VITAL RECORDS, P.O. BOX 68760	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed wi	DIRECTOR: After this certificate has been signed by the attending physician and compl
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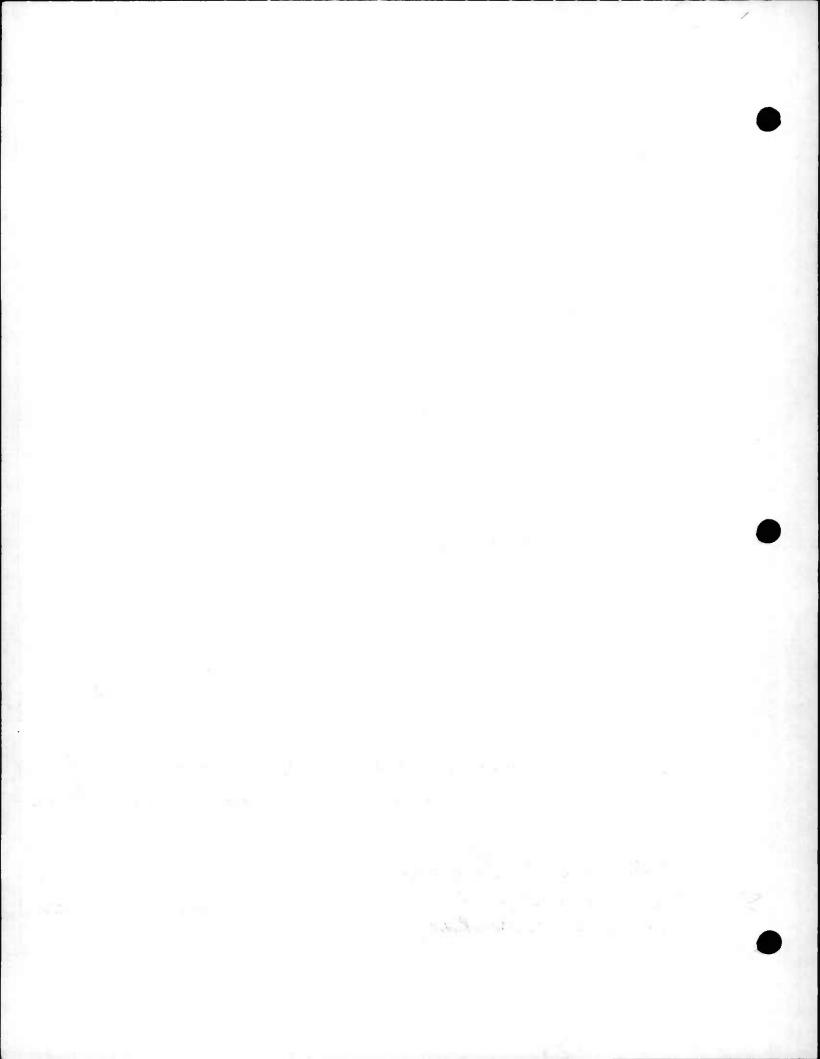
	1. DECEDENT'S NAME (First, Middle, Last	BRIVE ME	RSON			2. DATE OF DEATH	O.	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 577-38-248	5. SEX 6. AGE (In	yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8	95 8 CS P  BIRTHPLACE (State or Foreign Country)
	On EACH ITY NAME IN not lead to the		79 YRS.		OR LOCATION OF DE			MARYLAN (
TOR	ST. AGNOS HOSE 900 CATON A RESIDENCE OF DECEDENT	11446 100000			more			V/A
DIRECTOR	10a. STATE 10b. COUN MARYLAND N/F			ALTIN				10d. INSIDE CITY LIMITS? 1 X YES 2 NO
	100. STREET AND NUMBER 5/0 SUNSET			10	M. ZIP CODE 2./22	3		EN OF WHAT COUNTRY?
BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN S FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 NO	13. WAS DE	CENDENT OF HISPAN	VIC ORIGIN? (Specify Yon, Puerto Rican, etc.)		4. RACE — American Indian, Black, White, etc. Specify: White
TO BE COMPLETED	16. DECEDENT'S ED (Specify only highest grad	Ide. OECEDENT'S	USUAL OCCUPATI work done during m se retired.)	ON ost of working	16b. KIND OF BI	USINESS/INDUS		
	Elementary/Secondary (0-12)	College (1-4 or 5+)		erk erk		Reta	ai L	
	17. FATHER'S NAME (First, Middle, Last) HARRY S,	White				ME (First, Middle, Meide Tho		
TO B	190. INFORMANT'S NAME (Type/Print) Theresa Boo'	th	19b. MAILING	ADDRESS (Street	and Number or Rural i	Route Number, City or To	wn, State, Zip C	MD. 2122
	20e METHOD OF DISPOSITION TK Burlel 2 Cremetlon 3 Rei 4 Donetion 5 Other (Specify)	20b. P	LACE AND DATE	OF DISPOSITION (N Other place) ARK Cem	ame of	DATE 20c. L	OCATION — CI	ty or Town, State
	21. SIGNATURE OF FUNERAL SERVICE L		J.,					ARBUTUS MARYLAN' 2/227
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ED BY PHYSICIAN: MEDICAL	Sequentially list conditions, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other algnificant condition  DID TOBACCO USE CON  25. WAS CASE REFERRIO TO MEDICAL EXAMINER?  1	DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT  DUE TO (OR AS A COMPT	CONSEQUENCE O  ONSEQUENCE O  ONSEQUENCE O  ONSEQUENCE O  ONSEQUENCE O  ONSEQUENCE O  AT HOME, farm,  Oge, death occurr	Shock F: Line F): In the underlyin  TH (Check only one)  OTHER: 4   Nursing Hon  IE OF   28c. IN.  WY   1    street, tectory, office  ed at the time, date	UNCERTAIN  B S   Residence JURY AT JURY 2   NO	Part I. 24a. WAS AI PERFO 1  YES  6  Other (Specify)  28d. DESCRIBE HOW  281. LOCATION (Street City or Yown, State to the cause(s) and me	IN AUTOPSY DRMED? 2 NO INJURY OCCUI	Interval Betw Onset and D 5 day  5 day  24b. WERE AUTOPSY FIND ARALABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO  RED  Bural Route Number,
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or attending physician. r use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

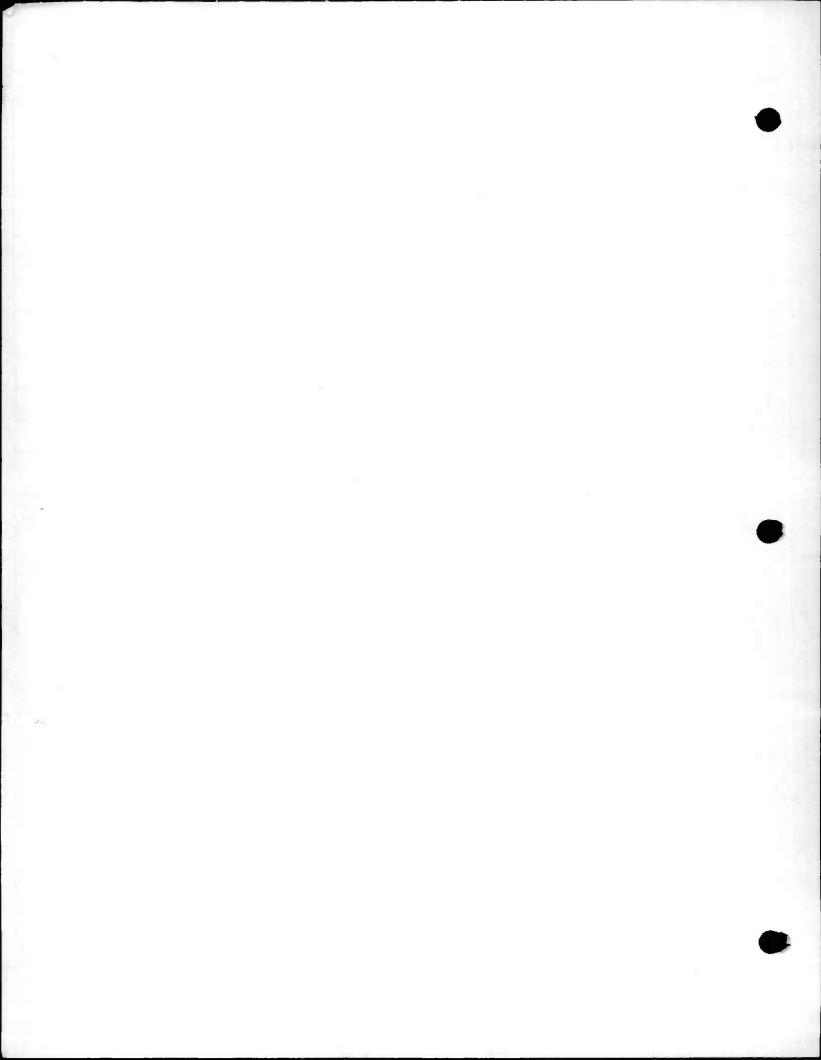
ifter death. Page 6 may be retained by the hospital of	y the funeral director, page 5 should be detached for oval.	cal examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing or hours after death. Page 6 may be retained by the hospital of	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for he filled within 72 hours after death with the State Deor, or Health and Mental Houlene prior to burial, premation, or removal	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN  26. PLACE OF DEATH (Check only one)  26. PLACE OF DEATH (Check only one)  27. WAS CASE REFERRED TO MEDICAL  EXAMINER?  1   Seption   1   Inpatient   2   ER/Outpatiant   3   DOA   4   Mursing Home   5   Residence   6   Other (Specify)  27. MANNER OF DEATH  1   Neturel   5   Pending Investigation   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. DATE OF INJURY   26. 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PERFORMED?  1 YES 2 NO  NAMILABLE PRIOR TO COMPLETION OF CAUSE OF PEATH?  1 YES 2 NO  1 YES 2 NO	TION	shock, or heart fature. I	DUE TO (OR A:	s a consequence of	It enter the mode of dying, su	, Elkridge, uch ss cardiac or resp	Md.	Approximate Interval Between	
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DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1\(\subseteq \text{YES 2}\) NO  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1\(\subseteq \text{YES 2}\) NO  26. PLACE OF DEATH (Check only one)  27. MANNER OF DEATH  1   Netural 5   Pending Investigation  28. DATE OF INJURY   26b. TIME OF INJURY WORK?  1   YES 2   NO   NO   NO   NO   NO   NO   NO	D BY PHYSICIAN: MEDICAL	SHOCK, or heart figure.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Sequentially list conditions, if sny, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in death) LAST  PART II. 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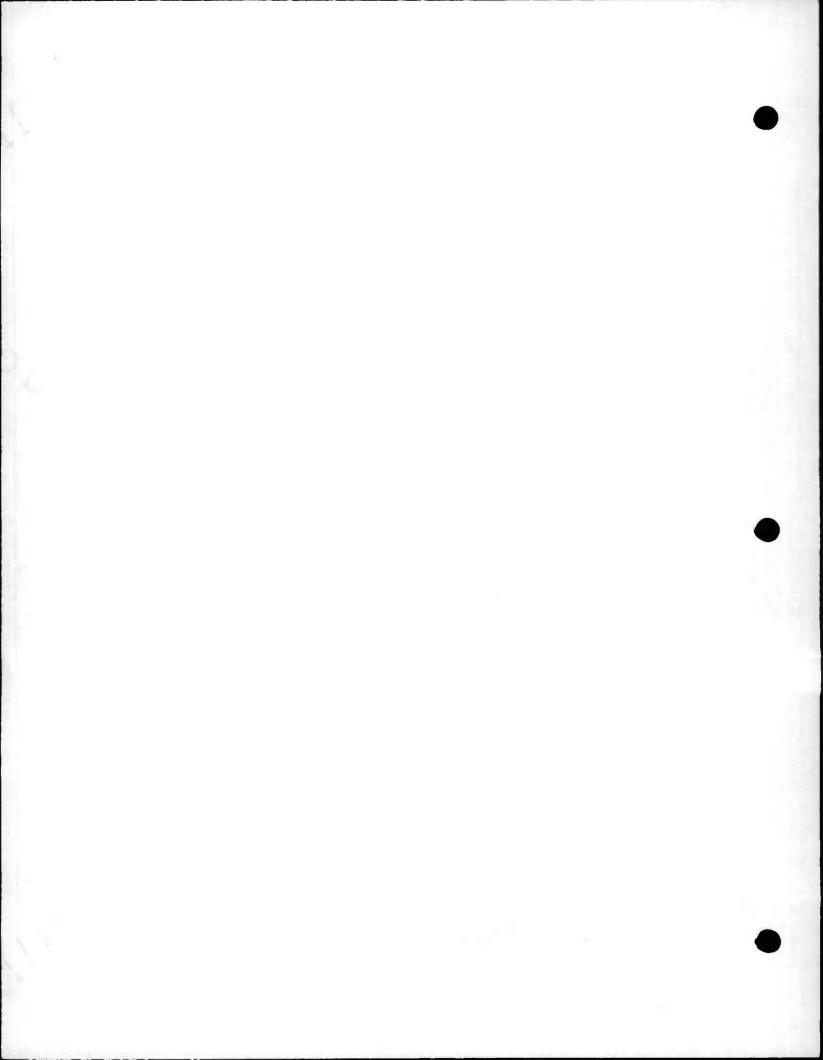


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	IOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be	UNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page	ithin 72 hours after death with the State Dent of Health and Mental Hydiene order to burial cremation or removal.

	1. DECEDENT'S NAME (First, Middle, Last)	son		ERIIF	ICATE (	F DEA	ГН	MONT		r 1/	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	Inst hirthday	IF UNDER 1 YE	AR IF UNDE	2.04.1400	Ma	Y 2 OF BIRTH	-	195	12:35 AM
	230-92-4669	1 ☑ M 2 ☐ F		35 YRS.	MONTHS DA		MIN.	(Mont	h, Day, Year)		Country)	
	9a. FACILITY NAME (If not institution, give	Λ		33	9h CITY TO	N OR LOCAT	ON OF DE		9, 19	9c. COUN		yland
H	Liberty Medical					timor		LAI!!		90. COON	n/a	AIR
STC.	RESIDENCE OF DECEDENT				Da.	CINOL	=				11/ d	
DIRECTOR	10a. STATE 10b. COUNT	Y		10c. CI1	TY, TOWN OR LO	CATION						10d. INSIDE CITY LIMITS?
	Maryland	n/a			Bal.t	imore						1 X YES 2 NO
FUNERAL	10e. STREET AND NUMBER					101. ZIP COD						HAT COUNTRY?
N.	5214 NOrwood Ave						207	USA				
5	1 Never Married 2 Married		YES 2		II yes	, specify Cubi	ın, Maxica	NIC ORIGIN	17 (Specify Yea Rican, atc.)	or No-	14. RACE Black,	- American Indian, White, atc.
B	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES		1 TES 2 NO Specify:							Black
2	15. DECEDENT'S EDU	JCATION	16a, I	DECEDENT'S	USUAL OCCU	ATION		166	. KIND OF BUS	INESS/INDU	JSTRY	DIACK
II.	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4 or 5		(Give kind of life. Do NOT u	work done during se retired.)	most of worki	ng					
Ę	High School			Bea	auticia	n			Cosmo	tolo	ЭУ	
COMPL	17. FATHER'S NAME (First, Middle, Last)	-				16. MOT	HER'S NA	ME (First,	Middle, Malden S	Sumame)		
BE	Curlie W. Mason					Ka	ther:	ine (	ray			
2	19a. INFORMANT'S NAME (Type/Print)  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
										and 21207		
	20a. METHOD OF DISPOSITION 1 X Burlai 2 Cremation 3 Ren	noval from State	20b. PLAC	E AND DATE	OF DISPOSITION	(Name of		Mary	E 20c. LOC	ATION C	ity or Tow	m, Sieta
	4 Donation 5 Other (Specify)	A	- Arbu	tus Me	emorial				4 Bal.t	imor	e Coi	unty, MD
	21. SIGNATURE OF PUNERAL SERVICE D	01			22. NAM 2501	GWVN	ss of fa 1s Fa	alls	tter F	uner	a.l. Ho	omes, Inc
	21. SIGNATURE OF FUNERAL SERVICE LICENSES  22. NAME AND ADDRESS OF FACILITY Nutter Funeral. Homes, 2501 Gwynns Falls Parkway  Baltimore, Maryland 21216  23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Appr											
	23. PART I. Enter the diseases, or shock, or beet failure	complications the	t caused the	death. Do	not enter the	mode of dy	ing, suc	h aa card	llac or reapir	atory arre	ent,	Approximata
- 1	IMMEDIATE CAUSE (Final								interval Between			
- 1		sease or condition										Onset and Death
	resulting in death)											1 4 days
	resulting in death)	DUE TO	(OR AS A CONS	SEOUENCE O				_	-			4days
NO		b. Se	OR AS A CONS	EOUENCE O	sorder							4days
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FICATION	Sequentially list conditions, if amy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	b. Se	OR AS A CONS 124 Y.E OR AS A CONS 260 OR AS A CONS	EQUENCE O	sorder blysis							4days 4days 4days
RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	b. Se	OR AS A CONS 124 Y.E OR AS A CONS 260 OR AS A CONS	EQUENCE O	sorder							4days 4days 4days
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART ii. Other aignificant condition  DID TOBACCO USE CONT  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO  27. MANNER OF OEATH  1 Netural 5 Pending investigation 3 Suicide 6 Could not be detarmined  29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER  29b. SIGNATURE AND TITLE OF CERTIFIER (Check only one) 1 MEDICAL EXAMIN	DUE TO  C. DUE TO  C. DUE TO  DUE TO  DUE TO  DUE TO  A CU  RIBUTE TO CA  HOSPITAL: 1 Inpatient 2  26a. DATE OF (Month, D)  26a. 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	_	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR				) MENT	AL HYGIENE REG. NO.			
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be retained to ge 5 should be notified	TO BE	190. INFORMANT'S NAME (Type/Print) MARY ROBINSON	MARY ROBINSON 1053 S. MARLYN AVENUE, BALTIMORE, MD						ode) , MD	21221		
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hir 24 hours aft tely filled in by mation, or remo		23. PART I. Enter the diseases, or come shock, or heart failure. List immediate CAUSE (Final disease or condition resulting in death)	c ardiac	ach Ilna.				uch aa ca	rdiac or reapira	itory arrea	t,	Approximate interval Between Onset and Death
OX 68760  e be executed with sician and comple infort to burial, creatment traumatic even	TION	Sequantially list conditions, if any, leading to immediata	ASPI POT	CONSEQUENCE OF	neui	mo	NIA					
P.O. E th certificat anding phy Hygiene p or other	ERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	Hypothy DUE TO (OR AS A Cardion	CONSEQUENCE DI	F):							
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로 크 2 드	COMPLET	2 MEDICAL EXAMINER: D	N: To the best of my knowlers the bests of examination								ause(a) and	d manner as stated.
TO THE HOSPIT TO THE FUNERA De filed within 7	TO BE (	29b. SIGNATURE AND TITLE OF CERTIFIER  Along C, Wulk	LIE M.D.	,			29c. LICENSE N	S65	2	Page DATES	IGNED (Mo	8 1995
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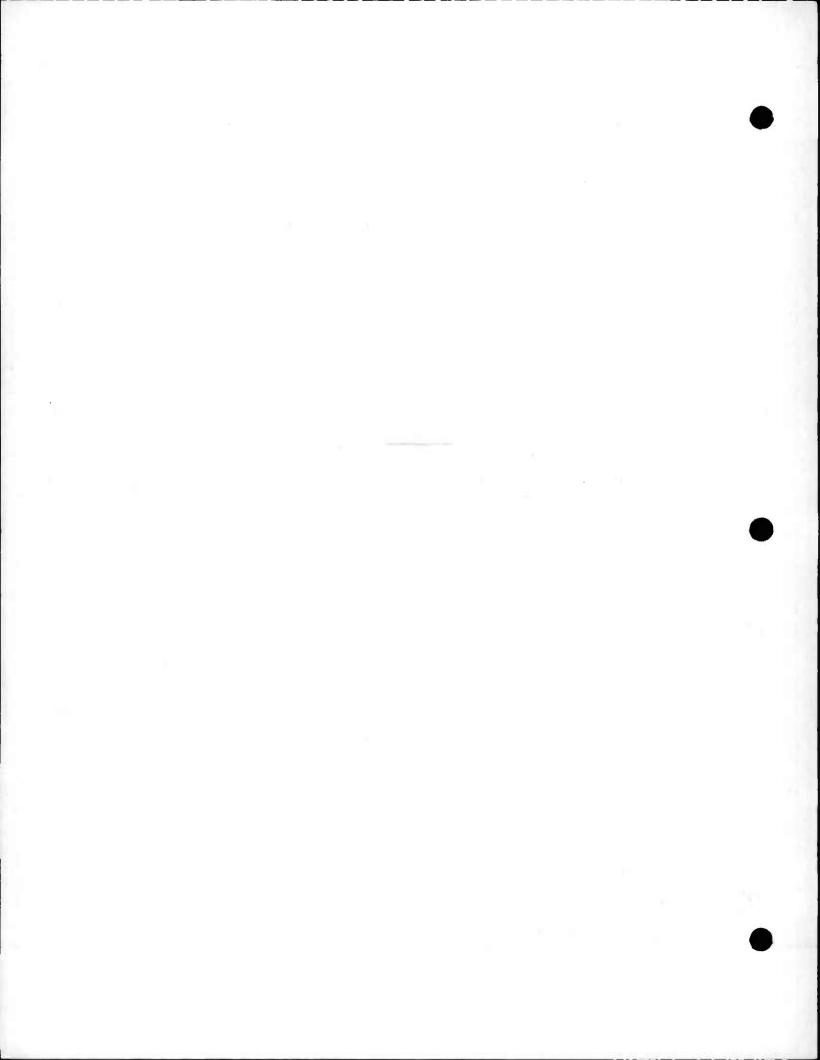
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	perm		
TO THE HOSPHALD HATTENDING PHYSICIAN: The law requires that the death certificate be executed within Fround after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 5 should be detached for use as the burial-transit perm		
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IAN: The la	rtificate has	he State De	or item 2:
HING PHYSIC	After this ce	death with the	marked,
DR ALTENL	DIRECTOR: ,	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or rem-	MPORTANT: if Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
HOSPINAL	FUNERAL	within 72 i	TANT: #
O THE	O THE	be filed	MPO

FilmG, 723, item #20b, 5/3/95, per f.h., cyw 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Mc C 330 Inez 5 5 -0 995 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 7/24/1910 213-18-1981 MONTHS DAYS HOURS 1 M 2 N F 84 YRS. Laurel, MD 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH RECTOR KESWICK HOME, BALTIMORE n/a RESIDENCE OF DECEDENT 10e. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND n/a BALTIMORE ō 1 X YES 2 | NO 10a. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10a, CITIZEN OF WHAT COUNTRY? 5220 YORK ROAD 21212 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Married Specify: Black В 3X Widowed 4 Divorced ETED 16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe (Give kind of work done ife. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Dept. Store COMPL Cook 8th 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Richard Wills Annie Hebron BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 233-15 Newport News, VA 23609 9 Richard Wills 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Nama of 20c. LOCATION - City or Town, State 1 N Buriel 2 Cremation 3 Removal from State Arounts Memorial Park5/4 Donetion (Specify) Arbutus, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207 Limber the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heert failure. List only one ceuse of each line. Intarval Between IMMEDIATE CAUSE (Final Onaat and Death diseese or condition resulting in desth) perfensive Cardishasenlar clise ase unkness DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequantistiy iist conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immedieta cause. Enter UNDERLYING CAUSE (Disease Dr Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in desth) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Infracorelial hemosphage Lebrually 1 TYES 2 NO 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \( \Boxed{1}\) NO \( \Boxed{1}\) UNCERTAIN \( \Boxed{1}\) 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER:
4 Nursing Home 5 - Residence 6 - Other (Specify) t YES 2 NO t 🗆 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. MANNER OF DEATH 28a. DATE DF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural 5 Pending 1 YES 2 NO BY 2 Accident 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28e. PLACE OF INJURY — At home, farm, streel, lactory, office building, atc. (Specify) 3 Suicide 6 Could not be 4 Homicide determined 29a. CERTIFIER 1 SCERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner as stated.



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Pages 1, 2, 3

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed witth, within a first death. Page 6 may be retained by the hospital or	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for us	
the hos	detach	be filed within 72 hours after death with the State UPD. Or Health and Methal Hydrele prior to buhal, cremation, or removal. IN 18th 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 2 DATE OF DEATH 3. TIME OF DEATH APRIL 925 8. BIRTHPLACE (State or Foreign Country) 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH (Month, Day, Year, 1 M 2XXF YRS 010-12-9946 84 July 12 1910 Maine 9s. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Washington Adventist Hospital Takoma Park. Montgomery RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Silver Spring Maryland Montgomery 1XXYES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20903 USA 8642 11th Avenue 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-II yee, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indien, Black, White, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY 3 X Widowed 4 Divorced White COMPLETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade compl (Give kind of work done life. Do NOT use retired.) Flementary/Secondary (0-12) College (1-4 or 5+) 12 Years Sales Person Department Store 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname, Katie Richardson notified at Julius Byer BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code 2 11203 Bybee Street, Silver Spring, Maryland 20902 Joel L. Nathan Pe 20b. PLACE AND DATE OF DISPOSITION (Name of 5/02/1995 ATE complany cramatory or other place) 20a. METHOD OF DISPOSITION 20c. LOCATION - City or Town, State must Burlel 2 Cremation 3 Read 4 Donation 5 Other (Specify) Olney, Maryland udean Memorial Gardens 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY STEIN HEBREW MEMORIAL FUNERAL HOME, INC. Gonald. 232 CARROLL ST, NW, WASHINGTON, DC 20012 medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one ceuse on Interval Between IMMEDIATE CAUSE (Final Onset end Death 中 disease or condition reaulting in death) event, Z Week traumatic CERTIFICATION Sequentially list conditiona, if any, leeding to immediate cause. Enter UNDERLYING none CAUSE (Disease or Injury other TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST 0 injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? any 1 TYES 2 NO Shows 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item EXAMINER? OTHER Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Reeldence 6 Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 90 COMPLETED 8 Could not be 4 Homicide 28 determined Hem 29e. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(s) end menner as stated. (Check only one) 2 MEDICAL EXAMINER: On the ition and/or investigation, in my opinion, death occured at the time, date 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

arro



2

MOBARAK

MAY U 3 1995

STOKE O JEY HAZO BO BLUAD ON PERMINDE AND ODOLED GIO

3. TIME OF DEATH

10d. INSIDE CITY

14. RACE — American Indien, Black, White, etc.

Jones

YES 2 NO

White

Approximate

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year) April 30,1995

NO

Interval Between

Onset and Death

8. BIRTHPLACE (State or Foreign

Maryland

10g. CITIZEN OF WHAT COUNTRY?

9c. COUNTY OF DEATH

N/A

IISA

11:20 A

2. DATE OF DEATH

April 29.

7. DATE OF BIRTH (Month, Day, Year 1 M 2 W 216-46-1580 May 14, 1911 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and nu 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 830 W. 40th Street Baltimore 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, intal Hygiene prior to burial, cremation, or removal. N/A Baltimore FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 830 W. 40th Street 21211 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexicen, Puerto Rican, atc.) BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2/ NO 1 Never Married 2 Married 3 Widowed 4 Divorced 1 TES 2 NO BY Specify COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Hame Once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumeme) notified at Charles Markell BE Jeanette 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Clark Murphy Jr 29 Susquehanna Avenue Towson, Maryland 21204 pe 20e. METHOD OF DISPOSITION
1 Disposition 3 Removal from State
4 Defiation 5 Disposity) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must metery, crematory or other place Metro Crematory 5/1 Baltimore, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212 medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each ilns. IMMEDIATE CAUSE (Final event, the disease or condition resulting in death) Memia DIVISION OF VITAL RECORDS, P.O. BOX 68760 he peoplew was uslay deso traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other that initiated events resulting in death) LAST 0 signed by the atter Health and Mental PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY MEDICAL PERFORMERS shows any 1 TYES 2 50 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ PHYSICIAN: . OR ATTENDING PHYSICIAN; The law DIRECTOR: After this certificate has by hours after death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate t EXAMINER? HOSPITAL: OTHER: NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 28e. OATE OF INJURY (Month, Day, Yeer) marked, 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident 5 Pending Investigation 1 YES 2 NO BY 3 Suicide 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 40 8 Could not be COMPLETED 4 Homicide 80 Rem 29e. CERTIFIER TO THE HOSPITAL O TO THE FUNERAL DI be filed within 72 ho IMPORTANT: If ite CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner as stated. (Check only one) estigation, in my opinion, death occured at the time, date end place, end due to the ceuse(s) and menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) E. Hunter Wilson M.D. 4 West University Parkway, Baltimore, Maryland 21218 31. DATE FILED (Month, Day, Year)
MAY 0 3 1995 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER 1 YEAR

IF UNDER 24 HRS.

PAGE

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

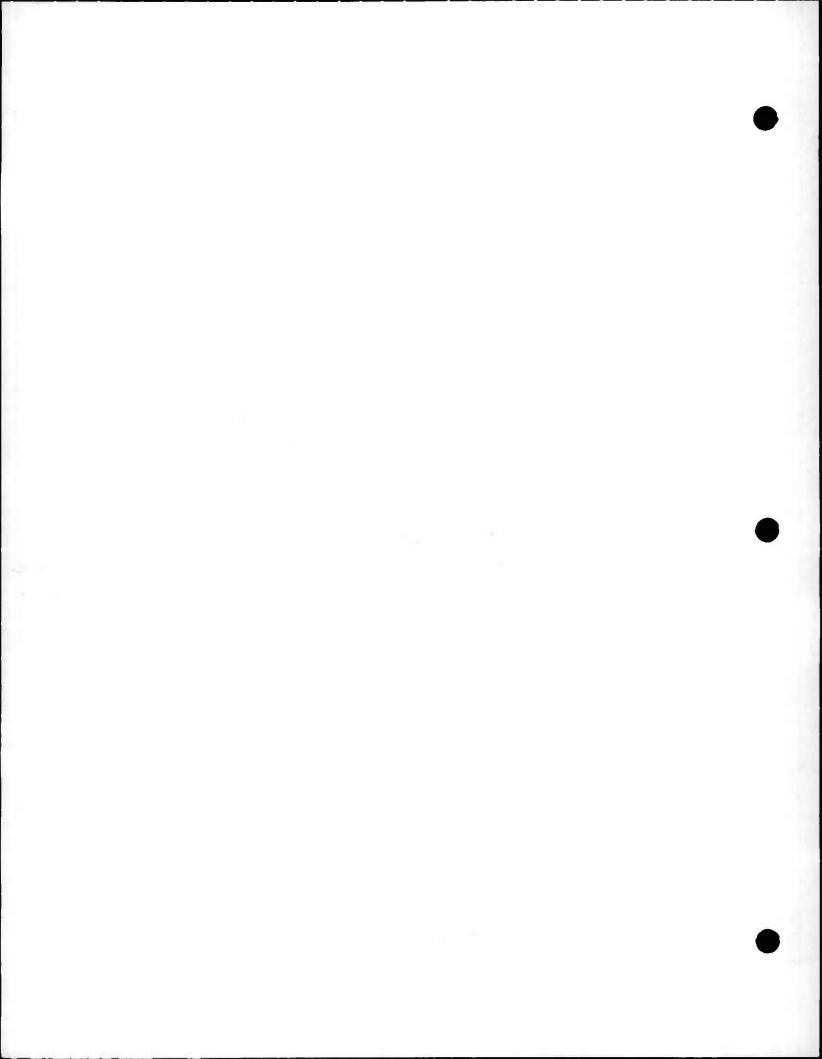
4. SOCIAL SECURITY NUMBER

**JEANETTE** 

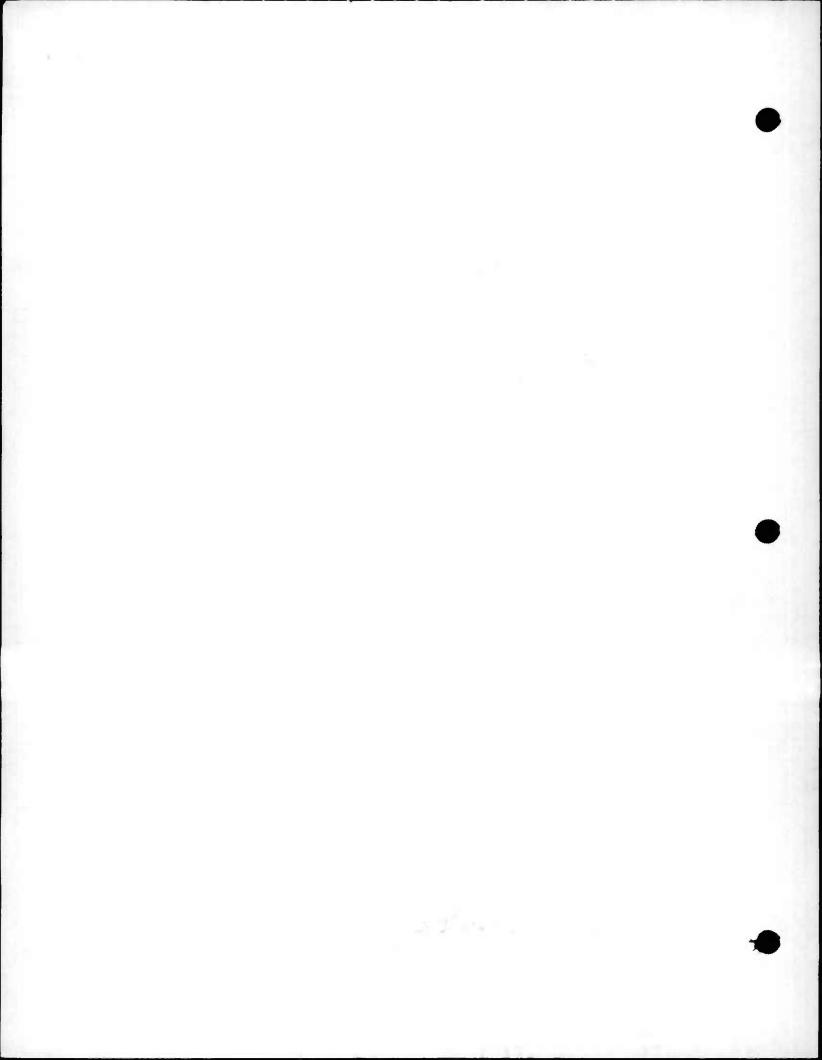
5. SEX

MARKELL

DHMH-16 Rev 1/89



		1 - STATE REGISTRAR	STATE UF MARYL		FICATE OF		D MENT	AL HYGIEN REG. NO	E		
		1. DECEDENT'S NAME (First, Middle, Las		1.			MON			YEAR 3.	TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	Grace V. Pe	Ltzen	IF UNDER 1 YEAR	IF UNDER 24 HF	Ma	E OF BIRTH	995	BIRTHRI	2:0/ P M  ACE (State or Foreign
_		214-24-7614	1 - M 2 - XF 9		MONTHS DAYS		(0.0-	nth, Day, Year)		Country)	
pinous	_	9a. FACILITY NAME (If not institution, given	re street and number)	-	9b. CITY, TOWN	OR LOCATION O		9.15,	90. COUNT	Y OF DEAT	Hand
2.3	CTOR	Good Samarit	an Hospital		Balt	Limore			1	1/A	
ages 1	ш	10a. STATE 10b. COU		10c. Cr	TY, TOWN OR LOC	ATION				10	d. INSIDE CITY
permit. Pages	L DIR		N/A		Baltimo						YES 2 NO
	FUNERAL	10e. STREET AND NUMBER	C.		1	10f. ZIP CODE					T COUNTRY?
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215-0020 attending physic se as the burial	Β¥	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YES		If yes,	specity Cuban, Me ES 2 NO Sp	xican, Puerto	Rican, etc.)		Black, W Specify:	White, etc.
use atte	TED	15. DECEDENT'S E (Specify only highest gra	DUCATION lide completed)	(Give kind of	Work done during r	TION most of working	16	b. KIND OF BUS	SINESS/INDUS	STRY	
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4 5 E	COMPLET	17. FATHER'S NAME (First, Middle, Lest)		Julen	Luuy		NAME (First,	Depart , Middle, Maiden	Surname)	Jto	one
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hours after of in by the or removal.		23. PART I. Enter the diseases, o	or complications that cause	d the desth. Do	not enter the m	node of dying,	ona a	rdiac or respi	ratory arres	<u>, μα.</u> t,	2/234   Approximate
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any any	DICAL	Escophytim /		1 oployon				PERFOR	MED?	AW	AILABLE PRIOR TO MPLETION OF CAUSE
Sign sign	MEC	DEWENT						T TES 2	200		DEATH?
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年 書 章	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 □ YES 2 □ NO	HOSPITAL:	26. PLACE OF DEA	OTHER:						
SICIAN: The Sizing the State of item	НХ	27. MANNER OF DEATH	1 Inpatient 2 ER/Out	28b. TIN	E OF 28c. IN	me 5 Rasiden		er (Specify) SCRIBE HOW II	NJURY OCCUP	RED	
After this death with	ВУ Р	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	JN.		YES 2 NO	0.00.00				
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12 12 12 12 12 12 12 12 12 12 12 12 12 1	COMPLETED		YSICIAN: To the best of my know								
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: IT I	E CC	29b. SIGNATURE AND TITLE OF CERTIF				29c. LICENSE		and piece, en			onth, Day, Year)
TO THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID THE ID	O BE	JIL L	- 67				427	6	Pyr. 7		, vaj, 1041)
	F	30. NAME AND ADDRESS OF PERSON I	VHO COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type	o, Print)					_	
10		Simon V. Scal		Balt	imore.	St. Ba	ltimo	ore. Md	. 212	224	
_ VI		MAY 0 3 1995	Alia Mudior	Revelle							



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

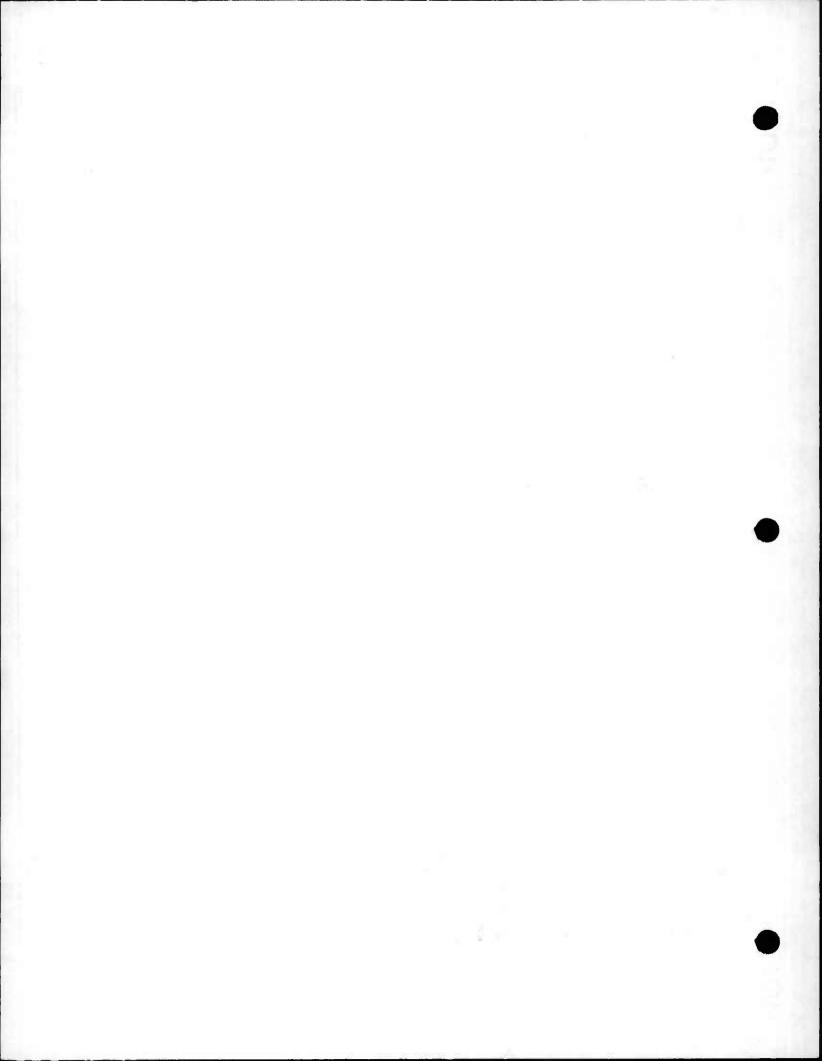
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a fire death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
AR	CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI				GIENE 3. NO.				
	1. DECEOENT'S NAME (First, Middle, Last)					2. DATE OF DE	ATH		3. TIME OF DEATH		
	Exie Crow	<i>d</i> er	Powell			April	26. 199	YEAR	9:20 A M		
				F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIR	ТН	8. BIRTH	PLACE (State or Foreign		
		1 🗆 M 2 🔀 F	89 YRS.	ONTHS DAYS	HOURS MIN.	June 25		Nort.	n Carolina		
_	9a. FACILITY NAME (If not institution, give street	of and number)	9	b. CITY, TOWN C	R LOCATION OF D			NTY OF DE			
FUNERAL DIRECTOR	Pikesville Convale	escent Home		P:	ikesvill	.e		Bal.t	imore		
REC	10a. STATE 10b. COUNTY		10c. CITY, T	10c. CITY, TOWH OR LOCATION					10d. INSIDE CITY		
<u> </u>	Maryland E	Baltimore		Pikesville				- 1	LIMITS?		
AL	10e. STREET AND NUMBER			101	ZIP CODE		10g. CIT	IZEN OF W	HAT COUNTRY?		
ij	7 Sudbrook Lane				21208			USA			
F	11. MARITAL STATUS 1 1 Never Married 2 Married	2. WAS DECEDENT EVER II FORCES? 1 YES	U.S. ARMEO	13. WAS DEC	NIC ORIGIN? (Spec	olfy Yes or No-	14. RACE Black	- American Indian, White, etc.			
B	3 Wildowed 4 Divorced	ATES	1 TES	2 NO Specif	fy:	110.1	Specif	y:			
	15. DECEDENT'S EQUICAT	TION	16a. DECEDENT'S US	IIAL OCCUPATIO		T est session			B1.ack		
	(Specify only highest grade co.	mpleted)	(Give kind of work	k done durina mo:	st of working	186, KIND	OF BUSINESS/IN	DUSTRY			
P	High School.	College (1-4 or 5 +)	Mai 1	Clerk		Princ	Prince Georges County Gov				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		PRAIJ.	CLGLK	18. MOTHER'S NA			62 C	Juilty GOV. E		
C	Richard Crowder				18. MOTHER'S NAME (First, Middle, Meiden Surname) Minnie Beard						
BE (	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street a			or Town State 7in	Code)			
임	198. INFORMANT'S NAME (Type/Print)  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Virginia Marshall.  615 Brickston Road Reisterstown, Maryla								land 21136		
	20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City of Town. S										
	4 Donation 5 Other (Specify)	John	netery, crematory or other						ounty, MD		
	21. SIGNATURE OF FUNERAL SERVICE LICEN			22. NAME AN	O ADDRESS OF FA	CILITYNT 1++	r Funar	a1 H	omes, Inc		
	HEURI Tan	Kenl		12301 (	MAINIO TO	arra car	ilway	. (1.1.	Olico, The		
	23. PART I Enter the diseases, or con	440	the death Do set		nore, Ma						
	nock, or neert issure. Lie	t only one ceuse on e	sch line.	enter the mo	ae or aying, auc	n as cardiac or	respiratory an	reet,	Approximate interval Between		
į	IMMEDIATE CAUSE (Finel disease or condition resulting in death)										
	reaulting in death) s		CONSEQUENCE OF):	7							
_	_		. /	10	ACT	INE	=c c	Tin	A 1		
<u>6</u>	Sequentially list conditions,  OULINARY TRACT INFECTION  OUE TO (OR AS A CONSEQUENCE OF):										
Ä	if any, leeding to immediate cause. Enter UNDERLYING										
Ē	CAUSE (Disesse or injury thet initieted events	DUE TO (OR AS A	CONSEQUENCE OF):								
CERTIFICATION	resulting in death) LAST										
	DADT II Other elections and tiles										
SAL	PART II. Other significant conditions of	contributing to death b	ut not resulting in t	he underlying	csuse given in	Part I. 24a. W	AS AN AUTOPSY ERFORMEO?		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
ă	- Marian		De	enetta			ES 2 NO		COMPLETION OF CAUSE OF DEATH?		
Σ		Decu	Cite	April 1	/				1 - YES 2 NO		
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIB			□ NO D	UNCERTAI	N 🔲			1		
o o	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	28. PLACE OF DEATH (	THER:							
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	1 Natural 5 Pending	(Month, Day, Year)	28b. TIME O	r woi	PK?	28d. DESCRIBE	HOW INJURY OC	CURED			
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요	3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, etc. (Spec	- At nome, term, streety)	et, factory, office		City or Town,	Street and Number State)	or Rural Ro	oute Number,		
щ	29e. CERTIFIER										
COMPLETED	(Check only CERTIFYING PHYSICIA	N: To the best of my knowl									
<u> ဂ</u>	Z P MEDICAL EXAMINER: (	On the basis of examination	and/or investigetion, in	n my opinion, de	ath occured at the	time, data and pla	ica, and due to th	in cause(s)	and manner as stated.		
BE	29b. SHAMATURE AND TITLE OF CERTIFIER	()	0.0	Mich	29c. LICENSE NUI	MBER C	29d. DAT	E SIGNED	Month, Day,		
2	Marros	- 12.	Comm		DZ	1600	) • (	+/	21/12		
	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DE	TH (ITEM 27) (Type, Pri	nt)	Lites	A	~	-	>1315		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE		1- 4-	- 4		7	21212		
	MAY 03 1995 Jahid	Rusher Real	t								



ITEMS: 23 PART I, 27, PER MEO FILM G-723 5/11/95 t.t

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 JADA APRIL REYNOLDS 28 11:44P onth, Day, Year, 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign 35 1 | M 2 MF 214 90 5769 MAR. 1960 MARYLAND 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR RANDALLSTOWN BALTIMORE RESIDENCE WESTER CENTER 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE BALTIMORE 1 TYES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3503 OAK COURT 21207 U.S OF A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 TES 2 NO BY 3 Widowed 4 Divorced Specify BLACK ED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY COMPLET ntary/Secondary (0-12) College (1-4 or 5+) 12TH UNEMPLOYED UNKNOWN 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) BRADFORD REYNOLDS BE OPHELIA SMITH 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MRS. OPAL THOMPSON 3503 OAK COURT BALTIMORE, MARYLAND 21207 20a METHOD OF DISPOSITION

1 Burlal 2 Cremation 3 Real OATE 20c. LOCATION - City or Town, State KING MEMORIAL PARK 5/3/95 Donation 5 - Other (Specify) RANDALLSTOWN MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE LEWIS /LEWIS T. GWYNN FUNERAL HOME 21215 GWYBN eurs -Turkn PARK HEIGHTS AVE. BALTO., MD. 4517 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or reepiratory arrest, shock, or heart feliure. List only one cause on each line. Approximate Interval Bety IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) MYOCARDIAL FIBROSIS DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | XER/Outpetient 3 | DOA OTHER: 1 YES 2 NO 4 🗆 Nı g Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED 1 X Netural 5 Pending M 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED 8 Could not be 4 Homicide COMPL 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 XMEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE O.C.M.E. ▶APRIL 29 1995 2 HO COMPLETEO PAUSE OF OEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201.

funeral director, page 5 should be detached for use as the burial-transit Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 hours after death. the and completely filled in by burial, cremation, or remo DIVISION OF VITAL RECORDS, P.O. BOX 68760 attending physician a signed by the atte Health and Mental t. of h has by Dept. certificate h OR ATTENDING PHYSICIAN: this c After t DIRECTOR: / HOSPITAL C FUNERAL D within 72 ho TO THE HOSPITAL
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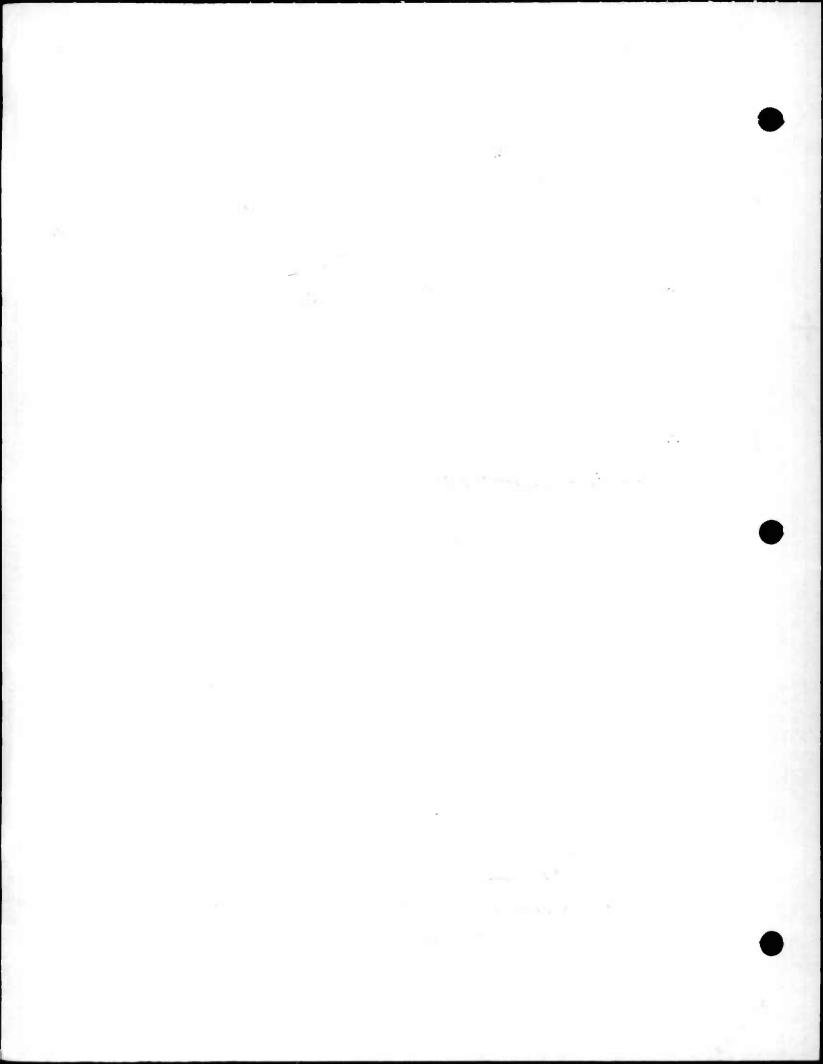
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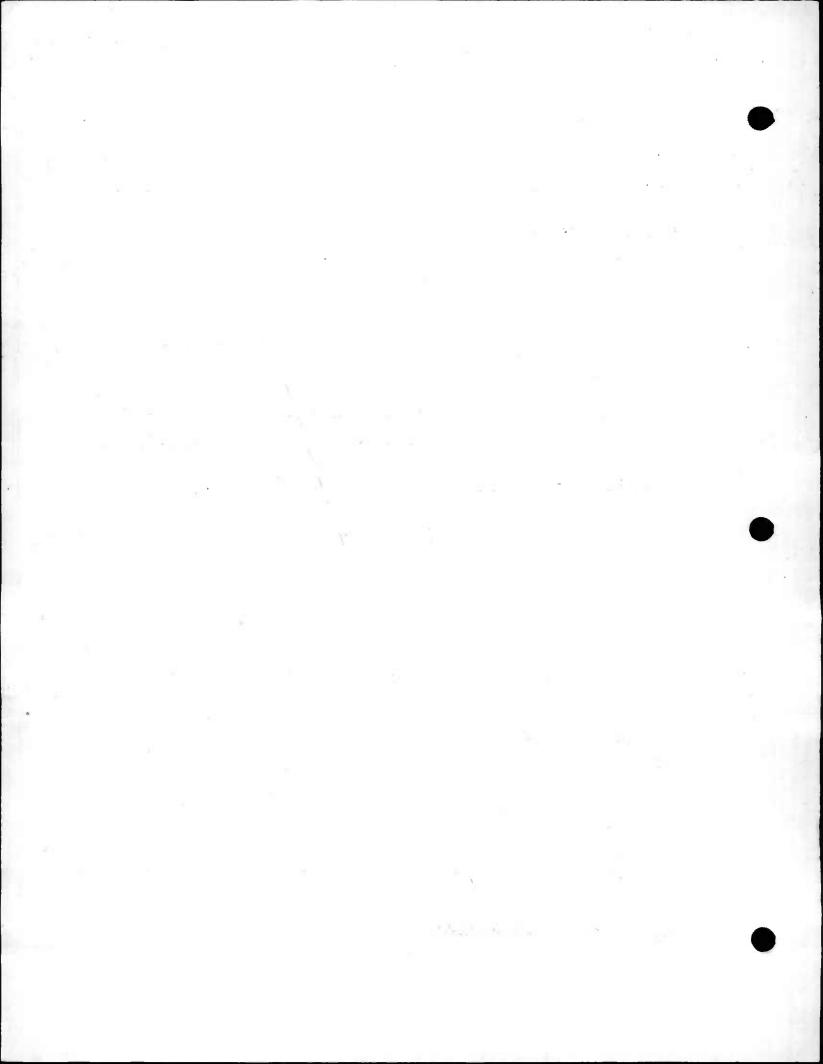
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the source after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	burs after death. Page 6 may be retained by the hospital or attending physician. I now the funeral director, page 5 should be detached for use as the burial-tran or removal.
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95 13322 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DOLORES REDING 04 745 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign FEBRUARY 2, 1928 1 M 2 X F 214-22-4683 67 BALTIMORE, MD. 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH SC COUNTY OF DEATH DIRECTOR SINAI HOSPITAL **BALTIMORE** BALTIMORE CITY RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYI AND HAREORO 1 - YES 2 X NO ABTNGDON FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3230 MEADOW VALLEY DRIVE 21009 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 YOU IF YES, GIVE WAR OR OATES 11. MARITAL STATUS 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuben, Mexicen, Puarto Rican, etc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY 3 Wildowed 4 Divorced WHITE COMPLETED 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) CLAIM CLERK 8 N/A SOCIAL SECURITY ADMINISTRATION notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) JOSEPH ZUBROWSKI HELEN GLASS BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 ELIZABETH J. SWAUGER 3230 MEADOW VALLEY DRIVE BALTIMORE, MARYLAND 21009 be 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State 1 X Burlai 2 Cremation 3 Removal from State
4 Oonetion 5 Other (Specify) PÄÄKWÖÖÖ CEMETERY MAY 2, 1995 BALTIMORE, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY LASSAHN FUNERAL HOME, INC. bottor 7401 BELATR ROAD BALTIMORE, MARYLAND 21236 23. PART I. Enter the dieeeeee, or complications that caused the death. Do not enter the mode of dying, euch as cardiac or respiretory errest, Approximate shock, or heart fellure. List only one ceuse on each line. Interval Between **IMMEDIATE CAUSE (Finel** Onset and Death disease or condition Neuroendocrine Tumor 2 months resulting in deeth) event, DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentielly liet conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in deeth) LAST 10 Injury. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? ANEMIA, Neutropenia, Thrombocytopenia, NIDDM. any Shows 2 1 TYES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER:
4 □ Nursing Home 5 □ Residence 8 □ Other (Specify) 1 YES 2 NO Unpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 28a, OATE OF INJURY 28b TIME OF 28c. INJURY AT WORK? marked, 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident INJURY 5 Pending Investigation M 1 YES 2 NO BY 3 Sulcide 28a. PLACE OF INJURY — At home, ferm, street, fectory, office building, afc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Homicide 28 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the filme, data and place, end due to the cause(s) and manner es stated. 2 MEDICAL EXAMINER: On the besis of ever ation and/or investigation, in my opinion, death occured at the time, date end piece, and due to the cause(s) end menner es atated. 29b. SIGNATURE AND TURLE OF CERTIFIER 29c. LICENSE NUMBER BE

29d. DATE SIGNEO (Mog(h, Day, Year)

+ 4/28/95 Duber MD PA5#9820 Medical Resident 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANIL K. DUBEY BALTIMORE, MD 21215 HOSP. OF PALTIMORE 31. DATE FILEO (Month, Day, Year) A REGISTRAR'S SIGNATUR MAY u 3 1995



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLAND	/ DEPART	MENT OF H	EALTH AND	MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)	0				2. DATE OF DEATH		3. TIME OF DEATH		
	Stanley L	KOSS				APN 30 1995 0210				
		S. SEX 6. AGE (In yrs. i		IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. B	IRTHPLACE (State or Foreign		
	-10 00 01-0	<del>X</del> M 2 □ F   78	YRS.			March 29,	1917 Ma	arýland		
Œ	9a. FACILITY NAME (If not institution, give street		- 1		R LOCATION OF D	EATN	9c. COUNTY C			
유	Northwest Hospital	Center		Randa11	stown		Balti	Lmore		
DIRECTOR	10a. STATE 10b. COUNTY		10c, CITY,	TOWN OR LOCAT	ION			10d. INSIGE CITY		
	Maryland Baltin	nore	Bal	timore				1 YES 2 NO		
M. M.	104. STREET AND NUMBER			101	212	0 /. /.	U.S.	OF WHAT COUNTRY?		
FUNERAL	2317 Kevsway Court	2. WAS DECEDENT EVER IN U.S. /	DIED	40 990 050						
	1 Never Married 2 Married	FORCES? 1 YES 2 TIF YES, GIVE WAR OR DATES	NO	If yes, sp	cify Cuban, Maxic	NIC ORIGIN? (Specify Yes an, Puerto Rican, atc.)		RACE — American Indian, Black, White, atc.		
BY	3 Widowed 4 Divorced	IF 123, GIFE HAN ON DATES		1 U YES	2 NO Specif	ly:	S	White		
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co		DECEDENT'S U	SUAL OCCUPATION done during mo	N at of working	16b. KIND OF BUS	SINESS/INDUSTR			
Ę	MO-DECRETATION OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT	College (1-4 or 5+)		rk done during mo retired.)		36	26			
×	Unknown  17. FATNER'S NAME (First, Middle, Lest)		Machin	ist			-Mariet	tta		
	Stanley L. Ro	ss. Sr.			Pearl	ME (First, Middle, Meiden	Sumame)			
BE	19a, INFORMANT'S NAME (Type/Print)		9b. MAILINO A	ADDRESS (Street a		Route Number, City or Tow	n State 7in Code			
5	Stanley L. Ross,	III	2317 K	evsway	Court, H	Baltimore,	Maryla	nd 21244		
	20a_METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Remove			DISPOSITION (Na			CATION — City o			
1	4 Donation 5 Other (Specify)	Cres	remetory or oth t Lawn	Memori			riotts	ville, Maryland		
	21. SIGNATURE OF FUNERAL SERVICE LICEN	1 - F O		A. Ala	n Seitz.	Jr. Funera	1 Home			
	N. allan	Deck y	7					Maryland 2121		
	23. PART I. Enter the diseases, or cor ahock, or haart fellure. Lis	nplications that caused the cost only one ceuse on each lin	aeth. Do no	t anter the mo	de of dylng, suc	ch as cardiac or respi	ratory arrest,	Approximata		
	IMMEDIATE CAUSE (Final	N		1	/ (	1		Onset and Death		
	disease or condition resulting in death)	14000	inu	ial -	Mai	Ction				
_	_	DUE TO (OR AS A CONS	EOUENCE OF).							
CERTIFICATION	Sequantially list conditions, if any, leading to immediate	DUE TO (OR AS A CONS	EOUENCE OF):							
SAT	cause. Entar UNDERLYING CAUSE (Disease or Injury									
표	that initiated events	DUE TO (OR AS A CONS	EOUENCE OF):							
H	resulting in death) LAST									
	PART II. Other significant conditions	contributing to deeth but not	resulting in	the undariying	cause given in			24b. WERE AUTOPSY FINDINGS		
ICA	AnoyicEn	cephalopo	thy			PERFOR	1	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
MEDI	Diabetes	Mellitus					ω, πο	DF DEATH?		
						_		X		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:		26. PL	ACE OF DEATH (Ch	eck only one)				
YSI	1 YES 2 NO	Inpatient 2 - ER/Outpatient	3 🗆 DOA   4	☐ Nursing Hom		6 - Other (Specify)				
1 1	27. MANNER OF DEATH  1. Natural 5 Pending	28a, DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	RY WO	NY?	28d. DESCRIBE NOW I	NJURY OCCURE			
ВУ	2 Accident Investigation	28e. PLACE OF INJURY At h	nome form etc		ES 2 NO					
E	3 Suicide S Could not be 4 Nomicide datarmined	building, etc. (Specify)	come, renim, str	eet, ractory, office		28f. LOCATION (Street a City or Town, State)	nd Number or Ru	rel Route Number,		
	29a. CERTIFIER	No. To the heat of multi-cut at a								
COMPLET		N: To the best of my knowledge, on the basis of examination and/or						selet and manner as stated		
	29b. SIGNATURE AND TITLE OF CERTIFIER	A								
BE	( O walnut	-1 M Bow	eles	40	29c, LICENSE NUI	877	DATE SIGN	NED (Month, Day, Year)		
2	30. NAME AND AODRESS OF PERSON WHO C	OMPLETEO CAUSE OF DEATH (IT	EM, 27) (Type, of	rint)	000	0 12	1/(41)	130,1795		
	Elizaleth M Bu	ike no.	Uld	(our	+Kd.	Kandal	Istow	In MD		
	MAY U 3 1995 July	32 REGISTRAR'S GNATURE								

Mary in a 1919 The Company of the Company

		1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGI				
		1. DECEDENT'S NAME (First, Middle, Las	0	_			2. DATE OF DEATH		YEAR 3. TIME OF DEATH		
		WILLIAM	3/0165	JR Will	iam Frank	Stokes, Jr	April-		995 6 84 M		
2		4. SOCIAL SECURITY NUMBER 213-62-3138	13(35M 2 □ F	(In yrs. last birthday) 40 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year 07-19-	)	BIRTHPLACE (State or Foreign Country)  MD •		
Should	_	9a. FACILITY NAME (If not institution, give				OR LOCATION OF DE			Y OF DEATH		
2, 3	CTOR	Joseph Ritch	ie Hospice		BALT	IMORE C	ITY	N	I/A		
permit. Pages 1,	DIREC	10a. STATE 10b. COUN	N/A		ALTIMO	RE CITY			10d. INSIDE CITY LIMITS?  1 X YES 2 NO		
bermi	4	10e. STREET AND NUMBER			101	f. ZIP CODE		10g. CITIZE	EN OF WHAT COUNTRY?		
ujan. Fransit	띮	1101 N. LAKE	WOOD AVENUE			21213		Ţ	J.S.A.		
dindentysion The burising	BY FUNERAL	11. MARITAL STATUS  1. Never Married 2 Married  3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 _ YES IF YES, GIVE WAR OR DA	2 NO	If yes, sp	DENDENT OF HISPAN Decity Cuban, Mexica 3 2 K NO Specifi	ric Origin? (Specify n, Puarto Rican, atc.)	Yea or No—	4. RACE — American Indian, Black, White, etc. Specify: BLACK		
UD)	Nea Bal	15. DECEDENT'S ED (Specify only highest gra-	DUCATION de completed)	16a. DECEDENT'S	USUAL OCCUPATION done during mo	ON pat of weaking	18b, KIND OF	BUSINESS/INDUS			
uny	座	Elementary/Secondary (0-12)	College (1-4 or 5+)	Iffe. Do NOT use	retired.)		TITON	OHERUD (			
V		12	N/A	RODA &	FENDER	REPAIR		CHEVRO	LET		
4 6 6	8	17. FATHER'S NAME (First, Middle, Last)	CEAUDO DE				ME (First, Middle, Maid				
2 6 6 6 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	BE	WILLIAM FRANK	STOKES, DR			ANN		HENR			
the retained age 5 should be notified	0		OKES, SR.				Noute Number, City or VE BALT				
e 5 may rector, p		20a. METHOD OF DISPOSITION 130 Burlat 2 Cremation 3 Ra 4 Donation 5 Other (Specify)	emoval from Stata com	netery, crematory or off ARYLAND			1	AUREL,	1000		
death. Pe funeral		22. NAME AND ADDRESS OF FACILITY BETTS FUNERAL HOME 1129 N. CAROLINE ST. BALTO, MD21213  23. PART / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate									
thin 24 hours after etely filled in by the emation, or remove nt, the medical		23. PART I knter the disease, of shock, or hard fillure immediate CAUSE (Final disease or condition resulting in death)	a. List only one cause on a	eth lina.	olga	oda of dying, auc	h aa cardlac or re	apiratory arrea	Approximate Interval Between Onset and Death		
ate be executed within pysician and complete prior to burial, crem r traumatic event,	CATION	Sequentially list conditions, If smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury) CAUSE (Disease or Injury)									
th certifical tending phy al Hygiene p or other	ERTIFI	that initiated events resulting in death) LAST	d.	LONSEQUENCE OF	PL		4.25-96				
that the deared by the att hand Menta	CAL C	PART II. Other algniticant condition	one contributing to death b	out not reaulting in	the undarlying	g cause given in	PERF	AN AUTOPSY FORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE		
SICIAN: The Jaw requires the certificate has been signed in the State Dept. of Health or Item 23 shows arr	MEDIC						_/	2 NO	OF DEATH?		
The law are has b are Dept.	SICIAN:	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH			114				
N: The State h	CI	EXAMINER?	HOSPITAL:		OTHER:			11			
certificant the S	HYS	27. MANNER OF DEATH	1 Inpetient 2 ER/Outp	28b, TIME		10 5 Rasidenca	6 Other (Specify) 28d. DESCRIBE HO	405/	eet '		
The tris	ву Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU	M 1 1	YES 2 NO	284. DESCRIBE HO	W INJURY OCCU	1ED		
OR ATTENDING DIRECTOR: After hours after death	ETED	3 Suicide 6 Could not b. 4 Homicide determined	e building, atc. (Spec	— At home, term, at	reat, factory, offic		281. LOCATION (Stre City or Town, Str	et and Number or ite)	Rurel Route Number,		
로 로 로 본	COMPLE		SICIAN: To the best of my knowl NER: On the basis of examination								
FUNER within		290. SIGNATURE AND TITLE OF-CERTIFI				29c. LICENSE NUM			SIGNED (Month, Day, Year)		
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2 2 3 3	٤	30. NAME AND ADDRESS OF BERSON W	YHO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Prjint)	2			1. 10		
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within the out of the death. Page 6 may be retained by the hospital or attending physicial	I THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
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31. DATE FILED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

O LUBLAT A

FAULKNER

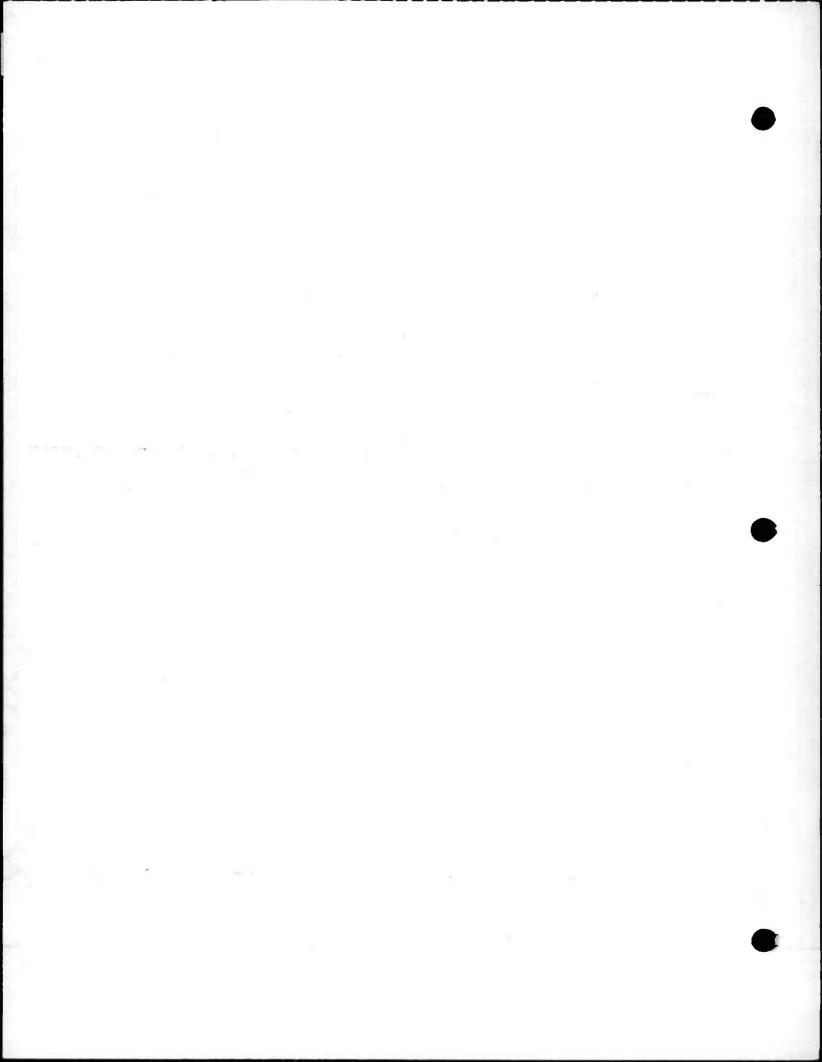
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR **CERTIFICATE OF DEATH** 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 540 A APRIL ANGELA CUSTY SCHMIDT 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. 214-24-4850 1 M 2 YRS 67 May 25, 1927 MARYLAND permit. Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR Stella Maris Hospice Towson <u>Baltimore</u> RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Towson 1 - YES 2 XXNO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1007 Rolandvue Road ansit 21204 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES YOUNG IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yea, specify Cuban, Mexican, Puerlo Rican, etc.) 14. RACE — American Indian, Black, Whita, atc. 1 Never Married 2XX Married 1 TES 2/1/NO Specify: ВY Specify 3 Widowed 4 Divorced White ETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION 18b, KIND OF BUSINESS/INOUSTRY (Give kind of work done during most of working life. Do NOT use retired.) (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Sales Agent Real Estate 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) notified at Gilbert Custv BE Elizabeth Hoover 19a, INFORMANT'S NAME (Type/Print 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Louis E. Schmidt 1007 Rolandvue Road Towson, Maryland 21204 pe 20a, METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must XXXIII 2 Cremation 3 Re Dulaney Valley Memorial Gardens nation 5 Other (Specify) Lutherville, Maryland examiner MONATURE OF FUNEY 22. HAME AND ADORESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore, MAryland 21212 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw IMMEDIATE CAUSE (Final **Onast and Death** the disease or condition resulting in death) MELANOMA event, DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other OUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST 0 injury, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY PINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY PERFORMED? any 1 WES 2 NO DE DEATH? Shows 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO I UNCERTAIN I 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one Tem. FXAMINER? HOSPITAL: OTHER 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Realdence (Specify) 6 Hospice 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF BEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural
2 Accident 5 Pending 1 YES 2 NO BY Investigation 3 Suicide 28a. PLACE OF INJURY — At home, farm, atreat, factory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is COMPLETED 4 Homicide Item ; 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE FUNERAL D be filed within 72 h (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIED 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE D25643 5 elmo 95 en

2300 DULANEY VALLEY RD.

TOWSON.

MD

21204



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last)  WARREN	G S	SCHUDE			2. DATE OF DEATH DA	AV YEAR	3. TIME OF DEATH	
							0,1995		
	217-16-8305	1 🕅 M 2 🗆 F		F UNDER 1 YEAR DAYS	HOURS MIN.	7. DATE OF BIRTH (Morith, Day, Year) Dec. 6,19	Coun	HPLACE (State or Foreign ity) 1119Sota	
	9a. FACILITY NAME (If not institution, give stre		9	b. CITY, TOWN	OR LOCATION OF D		9c. COUNTY OF	DEATH	
DIRECTOR	Good Samaritan Hos	spital		В	altimore			N/A	
JIRE	10a. STATE 10b. COUNTY Maryland Ba	altimore	10c. CITY, 1	TOWN OR LOCA	Balti	more	10d. INSIDE CITY LIMITS?		
	10e. STREET AND NUMBER			10	. ZIP CODE	MOLE	1 YES 24XNO		
FUNERAL	1435 Taylor Ave.				2	1234		States	
S		12. WAS DECEDENT EVER II FORCES? 1 X YES		13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specify Yes		CE — American Indian, ck, White, etc.	
BY	1 X Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR O	ATES	1 TYES	2 NO Specif	in, Puerto Rican, etc.) fy:	Spec		
	15. DECEDENT'S EDUCA	World War	16a. DECEDENT'S US	HAL OCCUPATION	W.	40. 1/110 05 011		WIIICE	
COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)		(Give kind of worldife. Do NOT use r	k done during mo	st of working	18b. KIND OF BUS	SINESS/INOUSTRY		
₽P.	12	2	Acco	untant		Koppe	r,s corp	poration	
Ö	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Middle, Maiden		02401011	
BE (	Warner	5	Schude11		Juli	a	UA	IKNOWN	
5	19a, INFORMANT'S NAME (Type/Print)		19b. MAILING AC	ORESS (Street a	nd Number or Rural	Route Number, City or Town	n, Stete, Zip Code)		
	Thomas E. Klug		21 W. S	usqueh	anna Ave	., Towson,			
	20s. METHOD OF DISPOSITION 1 Burial 2 X Cremation 3 Remove	rel from State car:	PLACE AND DATE OF I	nlacel			CATION — City or T		
o u	4 Donation 5 Other (Specify)	Gr	een Mount	Crema	LOTY 5/2	/95   Bal	timore	MD	
	> S410X	1)		CAFA	Stephen	D. Lohrman		21286	
_		mann		8717	Green P	astures Dr	., Balti	more MD	
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feliure. List only one ceuse on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  Due to (or As A consequence of):								
_									
Ó	Sequentielly liet conditions, If any, leading to immediate  b. Pheumonic  OUE TO (OR AS A CONSEQUENCE OF):								
S	cause. Enter UNDERLYING CAUSE (Disease or Injury							į	
E	that initiated events resulting in deeth) LAST	DUE TO (OR AS A	CONSEQUENCE OF):						
CERTIFICATION	d,								
PHYSICIAN: MEDICAL	PART II. Other algorificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I.  Chronic Obstructive fulnerary Disease  1 Yes 2 No OF DEATH?								
≥ :	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	E DEATH YES	ПИОГ	LINCEPTAIL	<u> </u>		1 YES 2 NO	
NA I	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH		ONCERIAII	10			
Sic		HOSPITAL:		THER:	5 🗆 Rasidenca	8 Other (Specify)			
E	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	F 28c, INJ	JRY AT	28d. DESCRIBE HOW IN	JURY OCCURED		
BY	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆 Y	ES 2 NO				
COMPLETED	3 Suicide 8 Could not be 4 Homicide detarmined	— At home, tarm, stre-	nome, term, street, factory, office 281			281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
7	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIA	AN: To the best of my knowl	edge, death occurred a	t the time, date	and place, and due	to the causels) and man	nor an eleted		
NO.	one) 2 MEDICAL EXAMINER:							s) and manner as stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIER			1	29c. LICENSE NUR		29d. DATE SIGNED		
TO BE	N. Morbroelde				P-07	614		30,1995	
F	30. NAME AND AGORESS OF PERSON WHO	COMPLETED CAUSE OF OE	ATH (ITEM 27) (Type, Pri	nt)					
	NASSER MOUKADDE	al 32. MEGISTRAR'S SANA	ATHRE.	MAN H	osp , 56	OI LOCH R	AVEN B	EVD, GALT, MD	
	MAY 0 3 1995 A	32. REGISTRAR'S SON	rlally						



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21 W. Susquehanna Ave., Towson, MD 21204

Green Mount Crematory 5/2/95 Baltimore MD

CAFA Stephen D. Lohrmann P.A. 21286 8717 Green Pastures Dr., Baltimore MD

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DIVISION OF VITAL RECORDS, P.O. BOA 88/80	HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after dea
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31. DATE FILEO (Month, Day, Year) MAY 0 3 1995

ANO ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Jan Danelson handel

M.D.

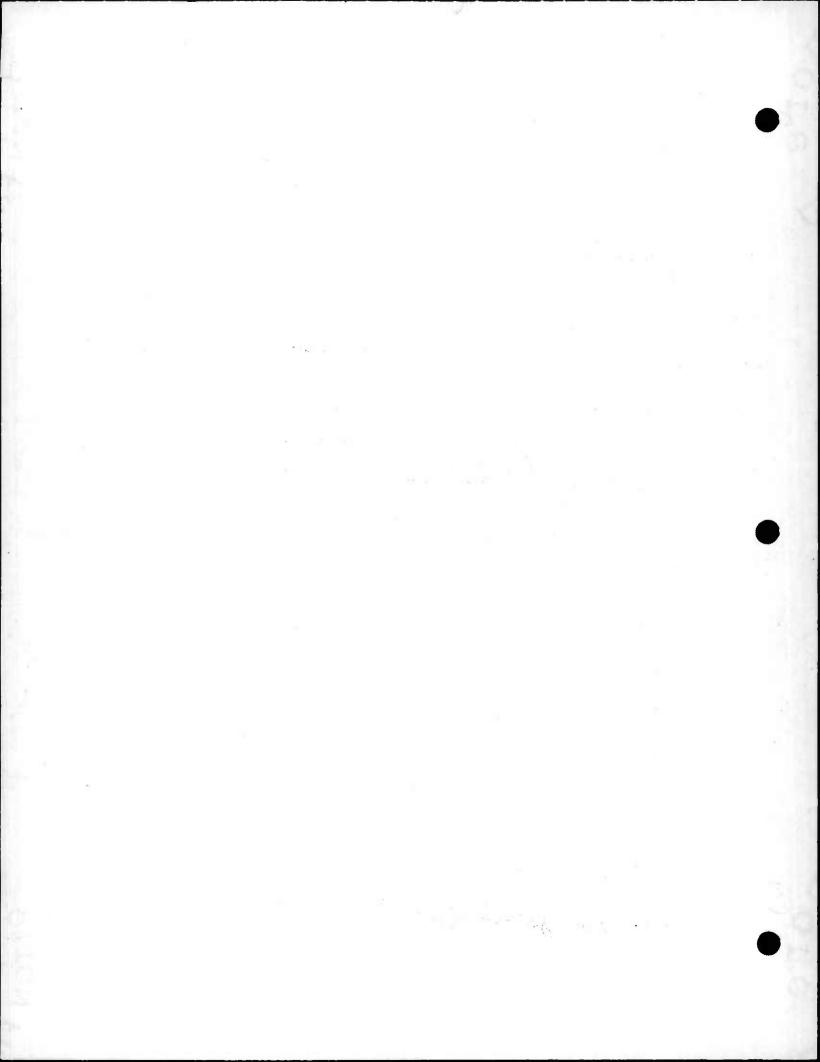
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Margaret M. Smith 1995 4:30 A M April 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year, 8. BIRTHPLACE (State or Foreign Country) IF UNDER 24 HRS. 1 - M 2 X F DAYS HOURS MIN 215-16-7986 76 April 19 Maryland Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 2112 Ashton St. Baltimore N/A RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. N/A Baltimore 1 YES 2 NO FUNERAL 10e, STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 2112 Ashton St. 21223 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—It yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY Specify: 3 Widowed 4 Divorced white COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ntary/Secondary (0-12) College (1-4 pr 5+) Nursing Assistant Nursing 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) te Lilburn Ady Elizabeth Burton BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Diane L. Burns 2112 Ashton St., Balto., Md. 21223 9 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State 1 | Burlel 2 | Cremetign 3 | Removal from State
4 | Donation 5 | Other (Specify) Must 4/26 The Green Mount Cemetery Baltimore, Md. examiner 21. SIGNATURE OF FUNE HAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. n by the fu 5695 Main St., Elkridge, Md. 21227 medicai 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory strest, shock, or heart after the mode of dying, such as cardiac or reapiratory strest, Approximata Interval Between 5 IMMEDIATE CAUSE (Final **Onset and Death** cremation, the disease or condition resulting in desth) brain tumor 1 month event, DUE TO (OR AS A CONSEQUENCE OF): in and com to burial, o traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if sny, lasding to immediate physician ne prior to cause. Enter UNDERLYING CAUSE (Disease or Injury other the attending phy Mental Hygiene ( DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST injury, or PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS and AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? PERFORMEO? shows any Health a 1 | YES 2 | DAG 1 YES 2 NO been . PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO TUNCERTAIN has b 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate to the State HOSPITAL: OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpetient 2 ER/Outpetient 3 DOA 9 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED this (with 1 Netural 5 Pending М 1 YES 2 NO BY After death 2 Accident 28s. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 99 COMPLETED 8 Could not be DIRECTOR: hours after 4 Homicide determined 28 1 CERTIFYING PHYSICIAN: To the beet of my knowledge, deeth occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) FUNERAL within 72 h 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) B OHa 140850 - MD 4.25-95

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BALTIMONE MD 21229



BALTIMORE, MARYLAND 21215-0020

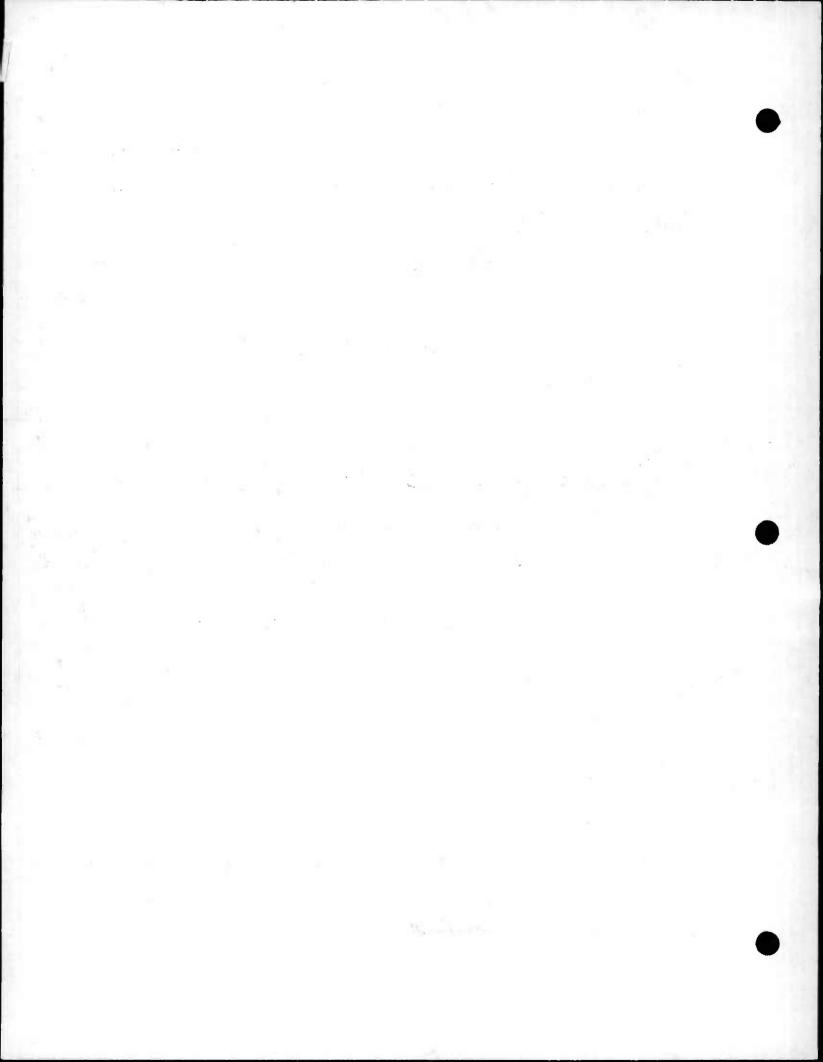
DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR ERTIFI	TMENT O	F HEALTH	AND	MENTA	L HYGIEN REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last) OKIA	C.			MOOT	1ER		MONTH DAY YEAR				3. TIME OF DEATN .
	4. SOCIAL SECURITY NUMBER 212-92-9857	5. SEX	6. AGE (in yrs. las	yrs.	IF UNDER 1 YE MONTHS DA		ER 24 HRS.	7 DATE	OF BIRTN	978	8. BIRTH	11:02P M PLACE (State or Foreign TIMORE, MD
<u>«</u>	9a. FACILITY NAME (If not institution, give JOHNS HOPKINS					MN OR LOCAL		EATN			NTY OF DE	ATN
2	RESIDENCE OF DECEDENT										11/ 0	
DIRECTOR	MARYLAND 10b. COUNT	n/a		10c. CITY	r, town or L	LTIMOF	RE					10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	1640 NORMAL A	E.				10f. ZIP COI	212	213		UN I		STATES
₽	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1	T EVER IN U.S. AR	MO If yes, specify, Cuban, Mexican, Puerto				N? (Specify Yea Ricen, atc.)	or No-	Black,	— American Indian, White, atc. BLACK	
LETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5	(G	ive kind of w Do NOT use	411.55		sing	164	. KIND OF BUS			
ONCE.	17. FATHER'S NAME (First, Middle, Last)	_		STUDE	EN1	18. MO	THER'S NA	AME (First,	HIG Middle, Maiden	H S(	CHOOL	
BEO	OLLIE TOOMER  19a. INFORMANT'S NAME (Type/Print)			- MAII INC	4000000 (O)		CARL	ENE	WILLI	AMS		
TO BE COM	SYLVIA WILLI		19	1640	G ADDRESS (Street and Number or Rural Route Number, City or Town, NORMAL AVENUE, BALTIMOR					m. State, Zip Code) IRE, MARYLAND # 13		
MUST	Complete 2 Cremation 3 Hamovat from State Complete Cremation or other place)							OCATION — City or Town, Stata ALTIMORE, MARYLAND				
Yalling.	21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  WM. C. MARCH FH1101 E. NORTH AVENUE											
CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, abook, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Fine) disease or condition resulting in death)  GUNSHOT WOUND OF BUTTOCK  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):											
MEDICAL	PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i.  PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i.  PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i.  PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i.  PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i.  PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i.  PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i.  PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i.  PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i.  PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i.  PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i.  PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i.  PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i.  PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i.  PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i.  PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i.  PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i.  PART I									AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  XXYES 2 NO	HOSPITAL:			OTHER:							
энх	27. MANNER OF DEATH	26a. DATE OF	INJURY	28b. TIME		INJURY AT	asidence		CRIBE NOW IN	JURY OCC	URED	
B	1 Natural 5 Pending 2 Accident Investigation 3 Suicide Could not be	4/02/	95"/	9:I		WORK?	X NO		SUBJECT.			
	4XX Homicide determined	STREE	atc. (Specify)			, mcg		2400	HOF FMAL	N ST.		IMORE, MD.
BE COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYS											and menner as stated.
B	29b. SIGNATURE AND TITLE OF CERTIFIES	1 - Chu	tino				ENSE NUM					Month, Day, Year)
10	30. NAME AND ADDRESS OF PERSON WAS					REET	RΔ1	T.TTM	DRE, MA	Δ.ΤΥΥ.Δ	ND	21201
	31. DATE FILED (MONT), Day Year) MAY 0 3 1995		HE CHAPT		01		, LA		JAMES TO SERVICE	44.4.4.14.		2207

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	M
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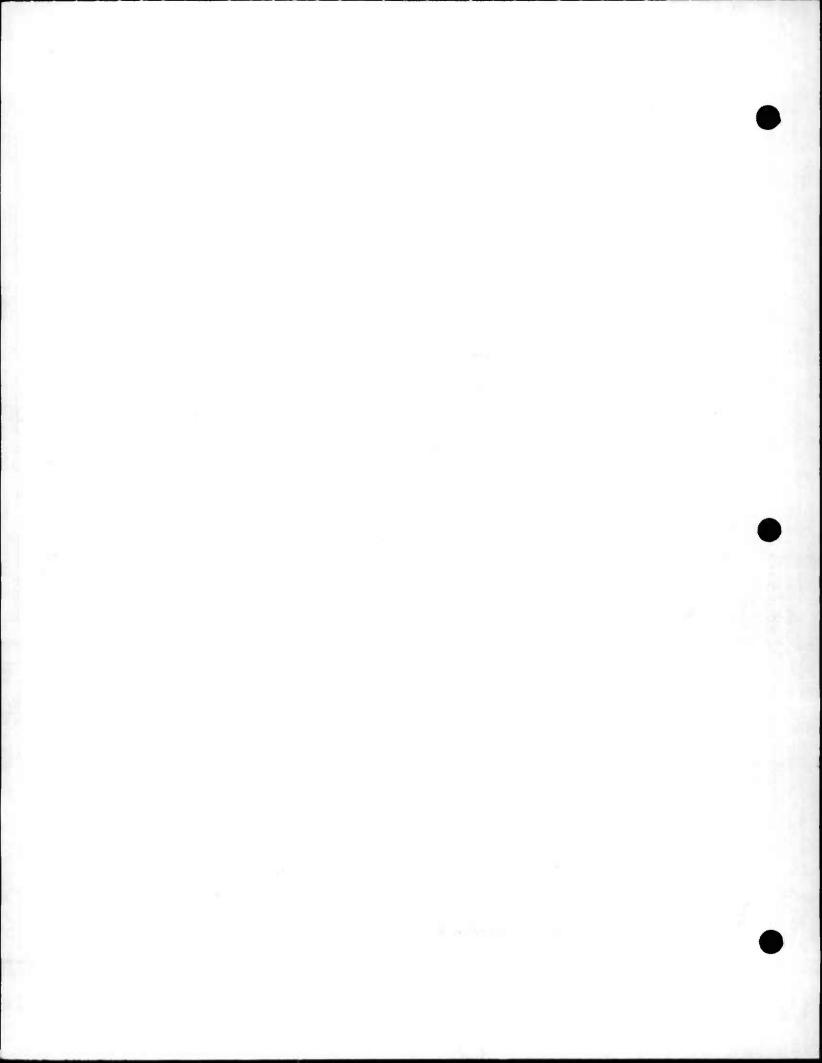
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle Last 2. DATE OF DEATH 3. TIME OF DEATN VILETA 00:59Am MAY 7. DATE OF BIRTH (Month, Pay, You 8. AGE (In yrs. lest birthday) JE UNDER 1 YEAR IF UNDER 24 HRS. Sept. 3 1 - M 2 TF HOURS New Jerse Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DIRECTOR HO timore 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MOre 1 YES 2 NO permit. FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 22 Dooker funeral director, page 5 should be detached for use as the burial-transit 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or Noif yea. specify Cuban, Maxican, Puerto Ricen, etc.) WAS DECEDENT EVER IN U.S. APPLED FORCES? 1 YES 2 WHO 11. MARITAL STATUS 14. RACE — American Indian, Black, White, atc. 2 Married If yes, specify Cuban, Maxican, Puarto Ri
1 YES 2 YNO Specify: 1 Never Married IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION ecify only highest grade comple 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INQUISTRY lery (0-12) ea (1-4 or 5+) Stan once. notified at BE 19a. INFORMANT'S NAME (Type/Print) 0 pe 20a. METNOD OF DISPOSITION
1 W Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Must 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICEL ICENSEE the medical 23. PART | Enter the eleeses, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or raspiratory arrest, shock, or ceart feiture. List only one ceuse on each line. à Approximate 2 interval Between ŏ IMMEDIATE CAUSE (Final Onset and Death marked, or item 23 shows any injury, or other traumatic event, the cremation, PNEUMONIA ASPIRATION diseese or condition and completely for burial, cremation resulting in death) OUE TO (OR AS A CONSEQUENCE OF): LZHEMIER PEMENTIA CERTIFICATION Sequentially list conditione, DUE TO (OR AS A CONSEQUENCE OF): 2 if any, leading to immediate cause. Enter UNDERLYING PERIPHERAL VASCULAR physician ene prior to YPERTEUSION CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST STATUS POST BOWEL RESECTION the atten Mental F PART II. Other aignificant conditions contributing to deeth but not reaulting in the underlying ceuse given in Pert I. 24a. WAS AN AUTOPSY PERFORMEO? MEDICAL signed by the AVAILABLE PRIOR TO COMPLETION DF CAUSE 1 YES 2 NO 1 TES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \( \Boxed{1}\) NO \( \boxed{1}\) UNCERTAIN \( \Boxed{1}\) has be Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: certificate to the State OTHER:
4 Nursing Home 5 Realdence 8 Other (Specify) 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 27. MANNER OF DEATH 28s. DATE OF INJURY 28h TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED this c 1 Watursi 5 Pending 1 YES 2 NO BY After 2 Accident 3 Suicide 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) item 28 is COMPLETED DIRECTOR: / 4 Homicide 29a. CERTIFIER TO THE HOSPITAL TO THE FUNERAL IS be filed within 72 h (Check only one) 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, BE Navori 244161436 MAY 2 WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 3001, SOUTH HANOVER STREET BALTIMORE BYTTAR N.S. 21225 MD 72. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year) MAY 0 3 1995



Pages 1, 2, 3 should

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ZA hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT Hism 28 is marked or item 23 shows any injury or other traumatic event the medical examiner must be notified at once
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									95	13330
	1 - STATE REGISTRAR	STATE OF MARY			TMENT OF			NTAL HYGIEN REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)	VENE	P					DATE OF DEATH DATE OF PRIL	žb 0	YEAR 12 35 PM
	4. SOCIAL SECURITY NUMBER		(In yrs. lest		IF UNDER 1 YEA	-		DATE OF BIRTH (Month, Day, Year)	1	BIRTHPLACE (State or Foreign Country)
	226-64-9767  90. FACILITY NAME (If not institution, give s	1 → M 2 □ F	45	YRS.		1,1550	N	ov 26, 1	949	Virginia
œ				İ		N OR LOCATIO	NE 15 1 D 5 0 5 1 1 1		9c. COUNT	TY OF DEATH
6	Northwest Hospita	l Center			<u>Ba1</u>	timore				n/a
DIRECTOR	10s. STATE 10b. COUNTY				, TOWN OR LO	CATION				10d. INSIDE CITY
		timore			Reiste	rstown				1 ☐ YES 2 X NO
FUNERAL	100, STREET AND NUMBER					10f, ZIP CODE			10g. CITIZI	EN OF WHAT COUNTRY?
NE	408 Valley Meadow						1136		L	USA
	1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I	2 XN	O	If yes,	specify Cuber	n, Mexican, Pu	RIGIN? (Specify Yes serto Rican, etc.)	or No-	<ol> <li>RACE — American Indian, Black, White, etc.</li> </ol>
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR ON	DATES		ייי	ES ZI NO	Specify:			Specify: Bl.ac}c
COMPLETED	15. DECEDENT'S EDU- (Specify only highest grade	CATION completed)	/Gh	ve kind of w	USUAL OCCUP	NTION most of working	a	16b. KIND OF BUS	SINESS/INDU	STRY
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT use	retired.)		•			
N N	6th Grade  17. FATHER'S NAME (First, Middle, Last)			Mech	anic				nobile	
ECC	Edward Veney							First, Middle, Melden	,	
0	19a. INFORMANT'S NAME (Type/Print)		19b.	MAILING	ADDRESS (Stre			Thompson Number, City or Town		Codel
2	Ora VEney / Tony	a Carroll	- 1		lley M					wn, MD 21136
	20. METHOD OF DISPOSITION 1 Duriel 2 Cremation 3 Rem	20	b. PLACEA	ND DATE O	F DISPOSITION	(Name of				ty or Town, State
	4 Donation 5 Other (Specify)	Mi	il.ber	ry C	hurch (	Cemete:	ry	30 Wars	saw, V	irginia
	21, SIGNATURE OF FUNERAL SERVICE LIC	IZ L			22. NAME	AND ADDRES	S OF FACILITY	Nutter .1s Parkw	Funer	al Homes, Inc
	per /	are			Bal:	imore	, Mary	land 21	.216	
	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiec or respiratory arrest, above, or heart feliure. Liet only one ceuse on each line.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):									
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):									
뜅	2000 11 211 1 111	0.								
18	PART II. Other aignificant condition	a contributing to deeth i	but not re	euiting in	the underly	Ing causa g	Iven in Part	I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
MEDICAL								1 TYES 2	NO	OF DEATH?
	DID TOBACCO USE CONTI	DIRLITE TO CAUSE (	SE DE AT	TLI VE	OND		EDTAIN! E	٦		1 TYES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	CAUSE C			H (Check only or		ERTAIN [			
Sic	EXAMINER?	HOSPITAL:			OTHER: 4 - Nursing H		sidence # [	Other (Speciful		
¥	27, MANNER OF DEATH	28e, DATE OF INJURY (Month, Day, Year)		28b. TIME	OF 28c.	NJURY AT		DESCRIBE HOW II	URY OCCU	RED
BY F	1 Natural 5 Pending 2 Accident Investigation	(Moran, Day, rear)		INJU		WORK? YES 2	NO			
	3 Suicide 6 Could not be determined 26a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 26b. PLACE OF INJURY — At home, term, street, factory, office City or Town, State) 26c. LOCATION (Street and Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or							Rural Route Number,		
COMPLETED		CIAN: To the best of my know								i, couse(s) end mattner as stated.
BE C	29h. SIGNATURE AND TITLE OF CENTIFIER	2= 2				29c, LICE	NSE NUMBER	$\overline{\Omega}$	29d. DATE	BIGNED (Month, Pay, Year)
일	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DE	EATH (ITEM	27) (Tune	Print)	1 y	457	50	- 7	120143
	HEMRY K-C	OSET N	DE		-E5T	the	XPI	TAL	,	
	MAY 0 3 1995	22. REGISTRAR'S SIGN	NATURE							



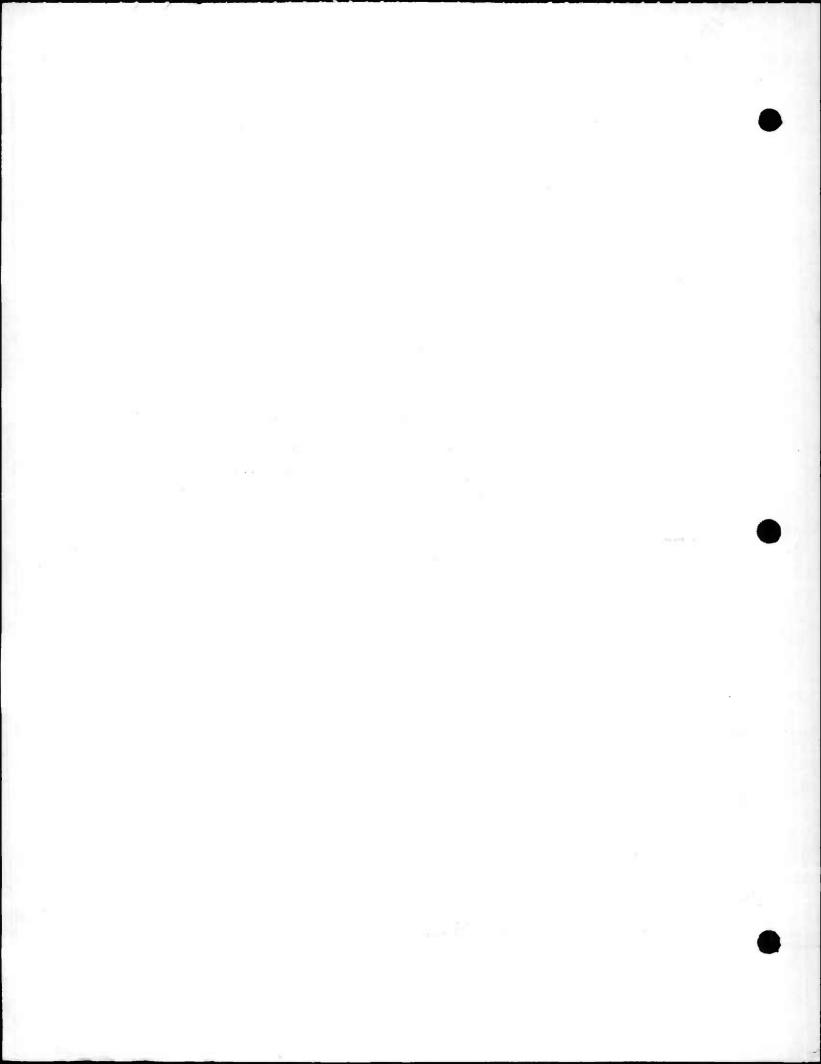
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020	executed within zer nours after death. Page 6 may be retained by the hospital or attending physician.	and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should
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DIVISION OF VITAL RECORDS, P.O. BOX 68

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 -

	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE	OF DEATH			3. TIME OF DEATH	
	GRA	CE B.	WHITE							APRI		.199	5	5:00 A. M	
1	4. SOCIAL SECURITY NUMBER	F-1	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER			R 24 HRS.	7. DATE (	OF DIOTH			PLACE (State or Foreign	
	218 01 30		1 □ M 2 💢 F	82	YRS.	MONTHS	DAYS	HOURS	MIN.	FEE	Dey, Year) 1	1913	VII	RGINIA	
~	9a. FACILITY NAME (If not in							OR LOCAT				9c. COU	NTY OF DE	EATH	
DIRECTOR	926 N		TON AVE	NUE		I	BAL'	TIMO	DRE			N/A	A		
EC	10a. STATE	10b. COUNTY	,		10c. CIT	Y, TOWN O	R LOCAT	TION						10d. INSIDE CITY LIMITS?	
9	MARYLAND	_ ]	N/A		В	ALT	MO	RE						1 X YES 2 NO	
AL	10e. STREET AND NUMBER						101	. ZIP COD	E			10g. CIT	IZEN OF W	/HAT COUNTRY?	
FUNERAL	926 NEWI	NGTON						2121	. 7			U.S	. OI	F A.	
J.	11. MARITAL STATUS  1 Never Married 2	Married	12. WAS DECEDER	T EVER IN U.S. AR	MED	13. V	VAS DEC	ENDENT	OF HISPA	NIC ORIGIN	? (Specify Year	or No-	14. RACE Black	— American Indien, , White, etc.	
BY	3 Widowed 4 Dive		IF YES, GIVE Y	MAR OR DATES		1	YES	2 X NO	Specif	fy:		- 1	Specif	BLACK	
	15. DEC	EDENT'S EDU	CATION	16a, DE	CEDENT'S	USUAL OC	CUPATIO	ON		16b.	KIND OF BUS	INESS/INC	DUSTRY	BEHOR	
	Elementary/Secondary (		College (1-4 or 5	+) life.	Do NOT us	e retired )	unng ma	ost of work	ing						
COMPLETED	N/A				NURS	E					PRIV	ATE	ניטם	TY NURSING	
	17. FATHER'S NAME (First, Middle, Last)  FERD HIGHTOWER  18. MOTHER'S NAME (First, Middle, Melden Surneme)  LULA COLE														
BE	19a. INFORMANT'S NAME (Type/Print)  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)														
5	JAMES D. NELSON  8334 LIBERTY ROAD BALTIMORE, MD. 21244														
1	206. METHOD OF DISPOSITION  206. METHOD OF DISPOSITION  206. PLACE AND DATE OF DISPOSITION (Name of 5/8/95 DATE  206. PLACE AND DATE OF DISPOSITION (Name of 5/8/95 DATE  206. DOLDCATION - City or Town, State  206. PLACE AND DATE OF DISPOSITION (Name of 5/8/95 DATE  206. DOLDCATION - City or Town, State  207. DOLDCATION - City or Town, State  208. PLACE AND DATE OF DISPOSITION (Name of 5/8/95 DATE  209. DOLDCATION - City or Town, State  209. PLACE AND DATE OF DISPOSITION (Name of 5/8/95 DATE  209. DOLDCATION - City or Town, State  209. PLACE AND DATE OF DISPOSITION (Name of 5/8/95 DATE  209. DOLDCATION - City or Town, State  209. PLACE AND DATE OF DISPOSITION (Name of 5/8/95 DATE  209. DOLDCATION - City or Town, State  209. PLACE AND DATE OF DISPOSITION (Name of 5/8/95 DATE  209. DOLDCATION - City or Town, State  209. DATE OF DISPOSITION (Name of 5/8/95 DATE  209. DATE OF DISPOSITION (Name of 5/8/95 DATE  209. DATE OF DISPOSITION (Name of 5/8/95 DATE  209. DATE OF DISPOSITION (Name of 5/8/95 DATE  209. DATE OF DISPOSITION (Name of 5/8/95 DATE  209. DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE O														
1	4 Donation 5 Other	(Specify)		Garri	son	For	est	Ve	t. (	Cem.	OWIN	<b>IGS</b>	MILI	LS, MD.	
- 1	21. SIGNATURE OF FUNERA	L SERVICE LIC	LLUY	IS T. (	GWYN	N T T	IAME A	ND ADDRE	SS OF FA	ACILITY		) A T	IIOMI	E 21215	
	Lew	es d	Luy	un		45	17	PAR	K H	ETCH	TC AT	(AL	HUMI	E 21215	
	23. PART i. Enter the d shock, or h	iseeses, Dr c	omplications the	it coused the de	eth. Do n	Dt enter	the mo	de of dy	ing, suc	ch as cerd	lec or reapi	ratory sri	rast,	Approximats	
	IMMEDIATE CAUSE (Fin	nei												Interval Batwaan Onaet and Death	
	diseese or condition resulting in death)	<b>→</b>	. Cere				*	CCi	Qe	ut				/wee/	
			DUE TO	(OR AS A CONSE	DUENCE OF	7):									
O.	Sequentially list condit if any, leading to imme		DUE TO	(OR AS A CONSEC	DUENCE OF	j:									
S	cause. Entar UNDERLY CAUSE (Disease or inju	ING	G												
E	that initiated events resulting in deeth) LAS		DUE TO	(OR AS A CONSE	DUENCE OF	ን:									
ER	resolding in deemy LAG		d												
MEDICAL CERTIFICATION	PART II. Other algnifica	nt condition				n the un	derlyin	g ceuse	given in	Part i.	24a. WAS AN		24b.	WERE AUTOPSY FINDINGS WAILABLE PRIOR TO	
OIC.	Diab	ete	5 Me	llitus							1 TES 2			COMPLETION OF CAUSE OF DEATH?	
ME														1 YES 2 NO	
Ä															
PHYSICIAN:	25. WAS CASE REFERRED T EXAMINER? 1 YES 2 NO	O MEDICAL	HOSPITAL:			OTHER		LACE OF U	DEATH (C)	neck only one	)				
HYS	27. MANNEB OF DEATH		26s. DATE OF	ER/Outpatient 3	28b. TIM		Ing Horr 28c. INJ		asidence	6 Other	(Specify) CRIBE HOW IN	LIURY OC	CUBED		
		Pending Investigation	(Month, L	Pay, Year)		URY M		PRK?	_ NO				OUNED		
D BY	2 C S total	Could not be	26a. PLACE (	OF INJURY At he atc. (Specify)	me, farm, s	treet, facto	ry, offic	•		28f. LOCA	TION (Street a	nd Number	or Rural R	loute Number,	
2	4 Homicide	determined		10,000.,,,						City C	iown, state)				
COMPLETED		TIFYING PHYSI	CIAN: To the best of	my knowladge, de	ath occurre	d at the ti	ne, data	and place	e, and dus	to the cau	se(s) end men	ner as atai	ted.		
Š	one) 2 MED	ICAL EXAMINE	R: On the besia of e	ramination and/or	investigatio	n, in my o _l	olnion, d	leath occu	ired at the	time, date	end pieca, and	d due to th	na cause(e)	end manner as stated.	
BE	296. SIGNATURE AND TITLE	OF CERTIFIE	Jacks	40 11	10			29c. LtC	ENSE NU	MBER	12	29d. DAT	E SIGNED	(Month, Day, Year)	
2	Moure	11 4	falls	DV 191	10.			1	120	177	2	- //	lay.	41445	
	30, NAME AND ADDRESS OF	- PERSON WA	COMPLETED CAU	SE OF DEATH (ITE	M 27) (Type,	Print)	10	0.4	4	1) 0	1	R.	91	n ninn	
	31. DATE FILED (Month, Day.	Year)	22. REGISTRA	AR'S SIGNATURE	UA	Ch	LKI	Cy.	971	LA	- DAO	DE	+617	0.2/22	
	MAY 03 199	5 Jul	in attention	March				U						1	
		-							_						

		1 - STATE REGISTRAR	STATE OF MA					EALTH DEAT		IENTAL	HYGIEN	E		
	1	1. DECEDENT'S NAME (First, Middle, Lest		mnp.						MONTH			YEAR	. TIME OF DEATH
		NELSON STANLET		TER  B. AGE (In yrs. la.	st birthday)	IF UNDER	1 YEAR	IF UNDER	24 HBS	MAY	OF BIRTH		.995	02:55 A M
_		215-05-9847	1 🔀 M 2 🗆 F	83	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month,	Day, Year)	1911	Country)	
3 should	_	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY,	TOWN C	PR LOCATIO	ON OF DEA		10,	9c. COUNT		
1, 2, 3	ЕСТОВ	GREATER BALTIMOR	E MEDICAL	CENTER		T	OWSO	N				BAL	TIMO	RE
Pages	DIREC	10a. STATE 10b. COUN			10c. CIT	Y, TOWN O	R LOCAT	ION	-				1	Od. INSIDE CITY
permit. F	AL D	Maryland Balt	timore			Towso	7	. ZIP CODE						☐ YES 2 XX NO
sit	1 1 1	7814 Ruxway Road	1				101.	2120					.S.A	AT COUNTRY?
020 physician. burial-transit	FUN	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT I			13. V	MAS DEC		F HISPANI	C ORIGIN	7 (Specify Yes	or No-	4. RACE -	- American Indian, White, atc.
5-0020 nding physic is the burial	В	3 Widowed 4 Divorced	IF YES, GIVE WAF					2X NO		, round n	ican, etc.)		Specify:	white
21 afte	8	15. DECEDENT'S ED (Specify only highest grad	UCATION de completed)			USUAL OC		ON st of working		16b.	KIND OF BUS	INESS/INDU	STRY	WILLCE
12 J	LET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life	Do NOT u	se retired.)	anny mo	or or working	•		_			
AND 2 the hospital detached for	COMP	17. FATHER'S NAME (First, Middle, Last)	5+ years	At	torn	ey		18. MOTH	ER'S NAM		Law	Sumamel	-	
# 8 6 Z	ш	Stanley J. Winte	er					Lily		- p #00, 10	rodie, maiden	_	ock	
MAR retained 5 should notified	10 B	19a. INFORMANT'S NAME (Type/Print)	( )					nd Number	or Rural Ro		er, City or Town	n, State, Zip C	Code)	
e age		Stephen C. Winte	r (son)	20b. PLACE					Rd.,	_	enix.			
Stor.		1 N Buriel 2 Cremation 3 Re- 4 Donation 5 Other (Specify)	movel from State	Grace	Ref	ther place) Ormed	Cer	meter	v Ma	DATE	Tane	CATION — CI		arvland
ALTIM death. Page e funeral direc l. examiner n		21. SIGNATURE OF FANERAL SERVICE	ICENSER	À		22.1	NAME AN	D ADDRES	S OF FACI	ILITY	Home		110 110	IL Y Land
		hous lo	uph bore	Y							i nome imore		21.21.3	)
urs af in by r remo		23. PART I. Enter the diseases, Di shock, or heart fellure	complications that of	ceused the de	eth. Do i	not anter	tha mod	de of dylr	ng, such	es cardi	lac Dr reapli	ratory arre	at,	Approximata Interval Between
24 □ □ □ □		iMMEDIATE CAUSE (Final disease or condition	Paca	1-6	<b>.</b>	Fil	ile	-						Onset and Death
ompletely if, cremati		resulting in desth)	DUE TO (O	R AS A CONSE	QUENCE O	F):	110(1	E						
executed and con o burial, matic en	N	Sequentielly list conditions,	Rospi Due to 10	monio	a.	- E		coli						2 weeks
or to	CATION	If sny, leading to immediate cause. Enter UNDERLYING	DUE TO (O	R AS A CONSE	OUENCE O	F):								
D. B. rtificate g physi iene pr	IFIC	CAUSE (Disesse or injury that initieted events	DUE TO (O	R AS A CONSE	OUENCE O	F):								
G, P.O. Brodeath certificate attending physiente pri	ERTIFI	resulting in death) LAST	d											
0 6 5 5	ICAL C	PART ii. Other eignificant condition			reaulting	In the un	derlying	j ceuse gi	lven in P	ert i.	24s. WAS AN			ERE AUTOPSY FINDINGS
	DIC		millation	~						_	PERFORI		C	VAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
- 5 5 5 E	MED	Cirrhosis								_				YES 2 NO
Las bas been 23	SICIAN:	DID TOBACCO USE CON' 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAU			S X N	_	UNCE	ERTAIN					
F VIIAL SICIAN: The law certificate has the State Dep	SIC	EXAMINER?	HOSPITAL:	tra-		OTHER	le .	5 🗆 Res	ildenca 8	☐ Other	(Specify)			
HYSICIA this certit with the	РНҮ	27. MANNER OF DEATH	26a. DATE OF IN (Month, Day,		28b. TIM		28c. INJU	JRY AT			CRIBE HOW IN	JURY OCCU	RED	· · · · · · · · · · · · · · · · · · ·
ON OP OP OP OP OP OP OP OP OP OP OP OP OP	В	1 Natural 5 Pending 2 Accident Investigation	200 PLACE OF	IN HIDY As be		М		ES 2 🗌						
28 L	ETED	3 Suicide 8 Could not be detarmined	28a, PLACE OF I building, etc	c. (Specify)	me, mm, :	nreel, mete	му, оппсе				TION (Street as r Town, State)	nd Number o	r Rurel Rou	te Number,
OR OUR	MPLE	29s. CERTIFIER (Check only)  CERTIFYINO PHY	SICIAN: To the best of my	y knowledge, de	eth occurr	ed at the tir	me, data	end place,	and due to	o the caus	e(s) and man	ner as stated	1.	
TO THE HOSPITAL OF THE FUNERAL (Defined within 72 h	COM		IER: On the basis of axan											nd manner as stated.
THE HOSP THE FUNEI filed within PORTANT	BE C	29b. SIGNATURE AND TITLE OF CERTIFI	ER				Т	29c. LICEN				29d. DATE	SIGNED (A	Ionth, Day, Year)
E E E	6	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAME	OF DEATH (ITT	M 27) /5	Orinth			3713			> 5	121	95
25		Donna L. Do	WM.D.	630	2/ N	. Ch	arle	+2 25	#12	5 B	ultime	ire, h	10	21217
		MAY 03 1995	32 HEGISTRAH	SMATURE										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within A hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burlal, cremation, or removal.

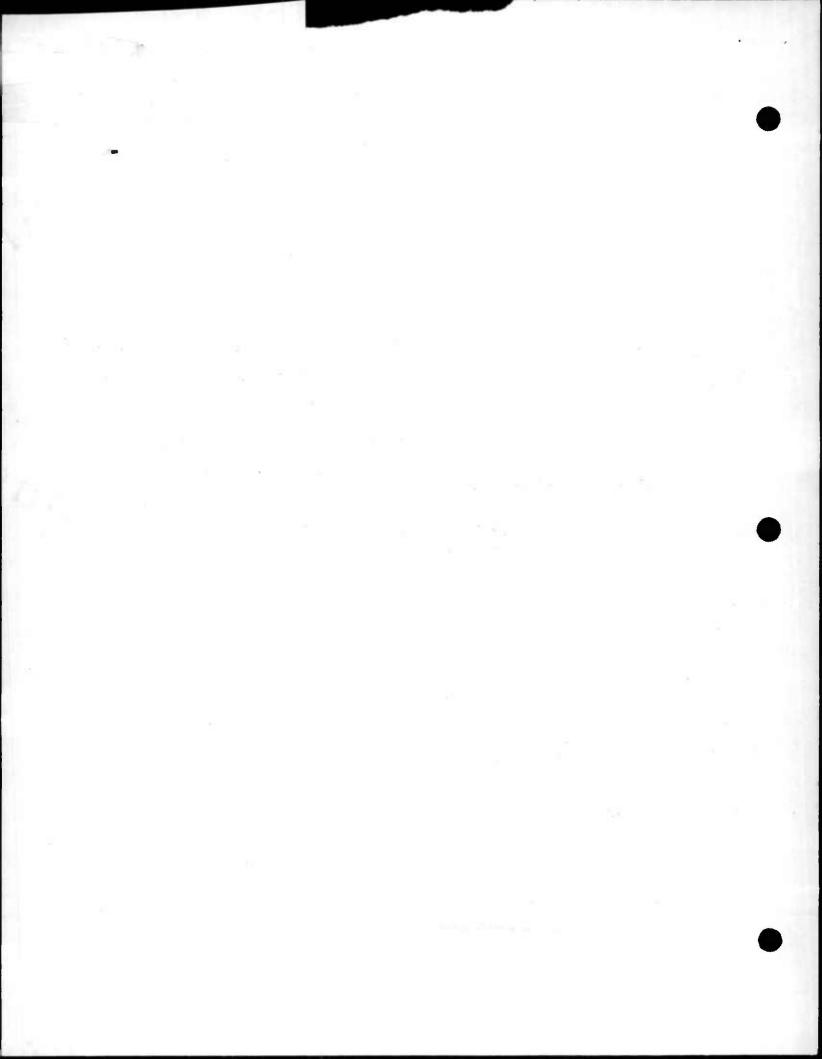
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		C	ERTIF	ICATE O	F DEATH	F	REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF			25743	3. TIME OF I	DEATH
	George ADAM		WES	т	. IR		April	28.	1995	YEAR	7:40	Р м
	4. SOCIAL SECURITY NUMBER	5. SEX (	B. AGE (in yrs. is		IF UNDER 1 YEA	R IF UNDER 24 HRS.	7. DATE OF	BIRTN	1000	a. BIRTI	HPLACE (State	
	219-30-0956 9a. FACILITY NAME (If not institution, give e		60	YRS.	MONTHS DAY		JANUARY	ly, Ybar)		BALT	IMORE. 1	MARYLAND
DIRECTOR	FRANKLIN SQUARE HOSP:				100	N OR LOCATION OF O	EATN			unty of d timo:		
<u> </u>	RESIDENCE OF DECEDENT  10e. STATE 10b. COUNTY	·		10c CIT	Y, TOWN OR LO	CATION						
<u>E</u>	DAL	TIMORE			LTIMORE (						10d. INSIDE	
ا ت	MARYLAND BAL  100, STREET AND NUMBER	THORE		_ DA	LITHOUR (	101. ZIP CODE			10. 017	TITEN OF I	1 TYES 2	
FUNERAL	4601 KENWOOD AVENUE					21206			US		WHAI COUNTR	147
5	11. MARITAL STATUS 1 Never Married 2 X Married	12. WAS DECEDENT FORCES? 1	EVER IN U.S. A	RMED	13. WAS D	ECENDENT OF NISPA specify Cuben, Mexico	NIC ORIGIN? (S	pecify Yes	or No-	14. RACI	E — American k, White, etc.	Indian,
BY	3 Wildowed 4 Divorced	FORCES? 1 FYES, OIVE WAI	R OR DATES			ES 2 NO Specif		.,,		Spec		
TEO	15. DECEDENT'S EDUI (Specify only highest grade	completed)		ECEDENT'S Give kind of DO NOT u	USUAL OCCUPI	TION most of working	16b. KII	D OF BU	SINESS/IN	OUSTRY		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+) N/A		F-EMPL			COM	IERCIA	L ROO	FING		
ğ	17. FATHER'S NAME (First, Middle, Last)					18. MOTNER'S NA	ME (First, Midd	le, Maiden	Surneme)			
BE C	GEORGE ADAM WEST SR.					MARGARET						
2	190. INFORMANT'S NAME (Type/Print) MARGARET WEST		- 1			et and Number or Rural						
	20e. METNOD OF DISPOSITION 1  Burlat 2  Cremetion 3  Rem.		-		OF DISPOSITION		OATE	_		City or To	nun State	-
İ	4 Donetion 8 Other (Specify)					MAY 2, 199				, MAR		
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE				AND ADDRESS OF FA HN FUNERAL I BELAIR ROAD		C.			000	
_	Common	2000			/401	BELATH HOAD	BALITMU	HE, M	IARYLA	ND 21	236	
ĺ	23. PART i. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line.  Approximately a such as cardiac or respiratory arrest, interval.											
	IMMEDIATE CAUSE (Final											and Death
	disease or condition resulting in death)	Cardiac									15m	in.
		Ischemic	RAS A CONSE									
CERTIFICATION	Sequentially list conditions,	b	OR AS A CONSE								2yea	rs
¥	If any, leading to immediate cause. Enter UNDERLYING	Coronary	arter	y di	sease						1,0	
프	CAUSE (Disease or Injury that initiated events	G	R AS A CONSE	-							10ye	ars
F	resulting in death) LAST	d.										
⋠┃	PART II. Other significant condition	a contributing to d	eath but not	reaulting	In the underly	ing ceuee given in	Part I. 24	PERFOR	AUTOPSY MED?	24b	. WERE AUTOPS	
EDICAL							1	YES 2	-XNO		COMPLETION DF DEATH7	OF CAUSE
ME							_				1 TES 2	□ NO
	DID TOBACCO USE CONTI	RIBUTE TO CAU					N 🔼					
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HQSPITAL:	28. PLA	CE OF DEA	TN (Check only or	ne)						
Z	1 TYES 2 NO	1 Dinpetient 2 D	ER/Outpatient	3 🗆 DOA	OTHER: 4 - Nursing H	ome 5 🗆 Residence	8 Other (Sp	ecify)				
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF IN (Month, Day,		28b. TIM		NJURY AT WORK?	28d. DESCRI	BE HOW I	NJURY OC	CURED		
B	1 1 Natural 5 Pending 2 Accident Investigation	1				YES 2 NO						
COMPLETED	3 Suicide 8 Could not be determined	28e. PLACE OF building, at	INJURY — At he c. (Specify)	ome, ferm,	street, fectory, o	fice	281. LOCATIO City or To	N (Street t wn, State)	and Numbe	r or Rural F	Poute Number,	
۳	290. CERTIFIER DECERTIFYING PHYSI	CIAN: To the heat of m	ni kaaniladaa d	anth account	4 3 4 4 4 4 4	resonate descrip	11.15-45	erra Unical	towan se			
29e. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and due to the my knowledge, death occurred at the time, date and piece, and due to the my one)  2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of the time, of											s) and menner	en stated.
Ö	29b. SIGNATURE AND TITLE OF CERTIFIER			_		29c. LICENSE NUI					(Month, Day, Y	
@	Leum le	ber M.	Δ.				9		<b>&gt;</b> (	-/	195	/
유	30. NAME AND ADDRESS OF PERSON WH		OF DEATH (ITE	M 27) (Type	, Print)	101311			7	120	1/3	
	Dr. Karen Leber	9000 Fran	nklin S			ltimore,	Maryla:	nd 2	1237			
	31. DATE FILED (MONTH, Day, Year)	32. REGISTRAR	SSIGNATURE									
- 1	MINI U D IDDD AW	A In smadery a	And Address of									

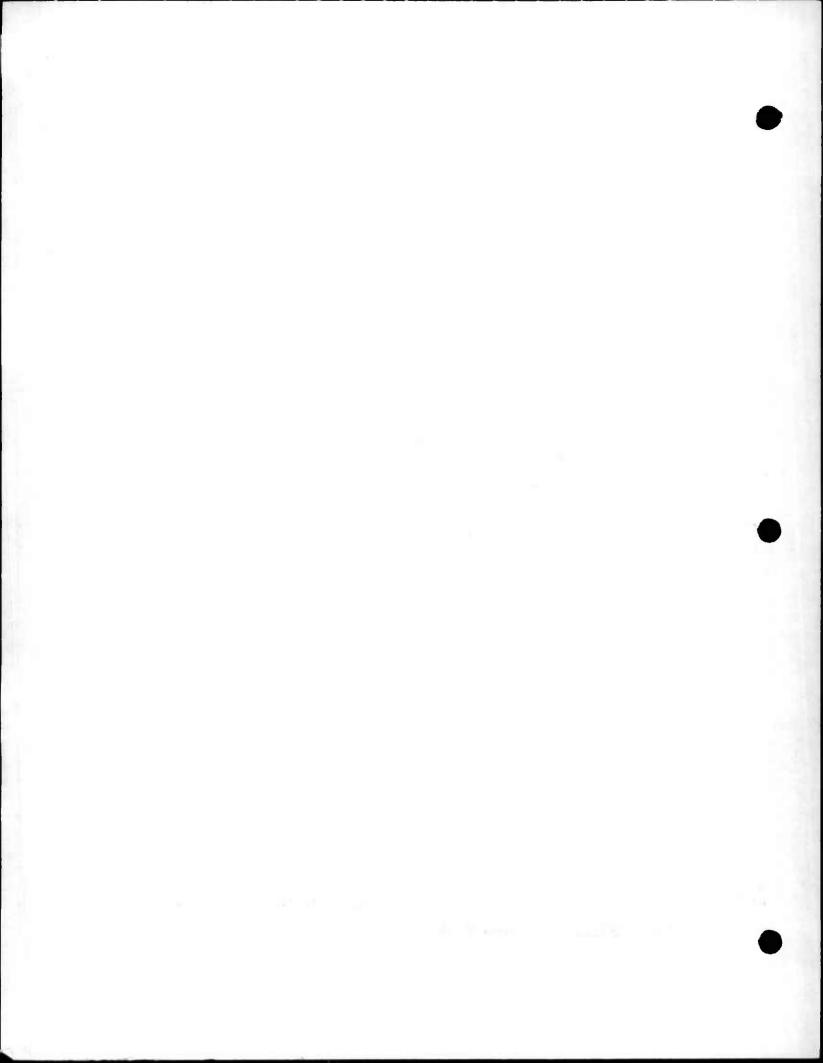


		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / [ CEI	EPARTME RTIFICA	NT OF H	EALTH AND DEATH	MENTA	L HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Last, HAZEL LOVISE	WOLFORD					2. DAT	E OF DEATH	AY	YEAR 3	TIME OF DEATH
Pin		4. SOCIAL SECURITY NUMBER 233-56-7735  90. FACILITY NAME (If not institution, give	1 - M 2 XF	(In yrs. last t	YRS. MONTH		IF UNDER 24 HRS. HOURS MIN.	JU.	of BIRTH	1936 T	ndep	ACE (State or Foreign endence, W.
1, 2, 3 should	CTOR	1001 Ensor Drive	street end number)			TOPPE	LOCATION OF D	EATH		9c. COUNT Harf		тн
permit. Pages	DIRE	100, STATE 106, COUNTY Ha:	rford		10c. CITY, TOW	PPA	IGN					Od. INSIDE CITY LIMITS?  YES 2 X NO
75	FUNERAL	100. STREET AND NUMBER	DRIVE			101.	21685	_			5A	AT COUNTRY?
215-0020 attending physician. se as the burial-transit	B	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 TYES IF YES, GIVE WAR GR D	2 X NO	ED	If yes, spe	ENDENT OF HISPA Icity Cuben, Mexic 2 NO Speci	en, Puerto	N? (Specify Yes Rican, etc.)		Specify: Whit	- American Indian, White, etc.
MARYLAND 21215-0020 retained by the hospital or attending physic 5 should be detached for use as the burial notified at once.	PLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)		(Give	DENT'S USUAL kind of work do to NOT use retire	e during mos	ON st of working		b. KIND OF BU	SINESS/INDU		
MARYLAND 2121 retained by the hospital or att 5 should be detached for use notified at once.	E COMPLET	17. FATHER'S NAME (First, Middle, Last)  Jay N. Trickett		Hete	411		18. MOTHER'S NA Hazel	ME (First,				
E, MAR' by be retained page 5 should be notified	TO B	190. INFORMANT'S NAME (Type/Print) Albert F. Wolfor	d	196.	MAILINO ADDRI 001 Ens	or Dr	nd Number or Rural `iVE	Aoute Nun	opa, Mo	n, State, Zip C	85	
BALTIMORE, or death. Page 6 may be the funeral director, page val.		20e. METHGD OF DISPOSITIGN 1 X Buriel 2 Cremation 3 Rer 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L	novel from State			tery	April 29			cation — ci llstor		
BALTIMORE, after death. Page 6 may be by the funeral director, page noval. cel examiner must be		18.77	assahn	ノ		E1750	Lassahi Belair	r Fur Road	peral H	Home ngsvil	le,M	d.21087
hin 24 hours tely filled in t mation, or re-		23. PART i. Enter the diseases, or ahock, or heert feilure immediate CAUSE (Final disease or condition resulting in desth)	a. NYFECALI	cemi	A	er the mod	de of dying, aud	ch aa car	diec or respi	iratory erres	it,	Approximate interval Between Onset and Death DAYS
P.O. BOX 68 ath certificate be executed the physician and all Hygiene prior to bur or other traumatik	CERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A DUE TO (OR AS A	CONSEQUE	VAL LEI ENCE OFI:	L CA	RCINOM	4				14K5MO
O that the day	MEDICAL (	Bush Cencer	na contributing to deeth b	out not res	ulting in the	underlying	cause given in	Part I.	24a, WAS AN PERFOR 1 YES 2	RMED?	CO	ERE AUTOPSY FINDINGS MILABLE PRIOR TO DMPLETION OF CAUSE F DEATH?
TAL The la te has ate De	PHYSICIAN: N	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE	GF DEATH (Che	k only one)						YES 2 NO
OF V PHYSICIAL this certiff with the ked, or	BY PHYS	1 YES 2 NG  27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28e. DATE GF INJURY (Month, Day, Year)		DOA 4 N	28c. INJU	FRES 2 NG		SCRIBE HGW II	NJURY OCCU	RED	
DIVISION OR ATTENDING F DIRECTOR: After hours after death item 28 is mer	ETED E	3 Suicide 8 Could not be 4 Homicide determined	28e, PLACE OF INJURY building, atc. (Spec	— At home	, ferm, street, f	ictory, office		281. LOC City	ATIGN (Street of Town, State)	and Number or	Rural Rout	le Number,
424	COMPL		IICIAN: To the best of my know ER: On the bests of exemination									nd menner se stated.
TO THE HOSPITA TO THE FUNERA Be filed within 7. IMPORTANT: I	TO BE	30. NAME AND ADDRESS OF PERSON WI	NG COMPLETED CAUSE OF DE				29c. LICENSE NUI	8-		29d. DATE S	13 P	onth, Day, Year)
8		JOHNS HOPKINS ONCOLUMNS HOPKINS ONCOLUMNS HOPKINS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLUMNS ONCOLU	064 COWTER 60 32. REGISTRAR'S SIGN.	NO!	10m ME	451	BaH.MO	212	8-7			

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4	The
DIVISION OF VITAL RECORDS, P.O. BOX 68760	OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after
VISION	ATTENDING
5	OR
_	OSPITAL

	1 - STATE REGISTRAR		MARYL	AND / DEPAR CERTIF	RTMEN ICATI	OF H	DEAT DEAT	AND ME	NTAL HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, I	Lest)		W	ILL:	IAMS	5	1		9,199	YEAR	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 228-34-8306	5. SEX 1 4M 2 F		in yrs. lest birthdey) 68 YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. 7.	(Month, Day, Year) 4/10/27			
Œ	9a. FACILITY NAME (If not institution,		<u> </u>		9b. CITY			ON OF DEAT		9c. COUNT	Y OF DEAT	TH
CTOR	1111 PARK AVE	Tele	<u> </u>		<u> </u>		MITL	ORE		BALT	0. C	ITY
DIRE	MD BA	LTO. CITY			SALTI							Od. INSIDE CITY LIMITS?  YES 2 NO
FUNERAL	100. STREET AND NUMBER 1111 PARK AVE			<u> </u>			21201			U.S		AT COUNTRY?
BY FUNE	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDER FORCES? IF YES, GIVE	1-T YES	2 NO		WAS DEC	ENDENT O	F HISPANIC	ORIGIN? (Specify Yes Puerto Rican, etc.)	or No — 14		- American Indian, White, etc.
ETED	15. DECEDENT'S (Specify only highest Elementary/Secondary (0-12)	EDUCATION grade completed)  College (1-4 or 5	+)	16a. DECEDENT'S (Give kind of life. Do NOT u	USUAL O work done se retired.)	CCUPATIO	ON st of workin	ng	16b. KINO OF BU			
COMPL	12	0		STEELL	WORK	ER			BETHLE		EEL	
ш	JAKE WILLIAMS	*		E-1274					(First, Middle, Meiden VILLIAMS	Surname)		
TO B	190. INFORMANT'S NAME (Type/Print) MAE WILLIAM								te Number, City or Tow . BALTO.			
	20e. METHOD OF DISPOSITION 1X Burlel 2 Cremetion 4 Donation 5 Object (Score)	Samoval from State		PLACE AND DATE				8/95		CATION — CH N BURN		
	22. NAME AND ADDRESS OF EACHTY ESTEP BROTHERS FUNERAL HOME 1300 EUTAW PLACE BALTO. MD 21217 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,   Approximate											
N	IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Pho	050	agh line.	. (				Let r			Approximate Interval Between Onset and Death
ERTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c		CONSEQUENCE O								
MEDICAL C	PART II. Other algnificant cond	Cin Una	death be	ut not resulting	in the ur	derlying	g cause g	given in Pa	PERFOR	RMED?	CO	ERE AUTOPSY FINDINGS WAILABLE PRIOR TO DMPLETION OF CAUSE F DEATH?  YES 2 NO
	DID TOBACCO USE CO						UNC	ERTAIN	<b>1</b> 2		L.	_ TES 2 _ NO
SICIAN:	25. WAS CASE REFERRED TO MEOIC. EXAMINER?  1 ☑ YES 2 □ NO	HOSPITAL:		28. PLACE OF OEA	OTHER	₹:	5 VI Ro	eldence 8 [	Other (Specify)			
PHY	27. MANNER OF DEATH  1 Netural 5 Pending Investigat	28a. OATE OF	F INJURY	28b, TIN	-	28c, INJ	4 %	20	d. DESCRIBE HOW I	NJURY OCCU	RED	
TED BY	2 Accident investigat 3 Suicide a Could no 4 Homicide detarmine	28a. PLACE C	OF INJURY , atc. (Spec	— At home, farm,	street, fact	ory, office		28	81. LOCATION (Street a City or Town, State)	and Number or	Rural Rout	te Number,
COMPLETE		HYSICIAN: To the best of MINER: On the basis of a										nd manner as stated.
BE	29b. SIGNATURE AND TITLE OF CEN	PER PL	1					ENSE NUMBE	R			30 , 1995
2	30. NAME AND ADDRESS OF PERSON	Fowler		111 P		Stı	ceet	, Ba	ltimore	, Mar	ylaı	nd 21201
	31. DATE FILED (Month, Day, Year)	32 REGISTRA	AR'S SIGN	ATURE								



JOHN WILLIAMS 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR IF UNDER 24 HRS. 5. SEX 6. AGE (In yrs. lest birthday) FEB. 1X M 2 | F 426-34-5623 68 nours after death. Page 6 may be retained by the hospital or attending physician.
In by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR FREDERICK MEMORIAL HOSPITAL FREDERICK RESIDENCE OF DECEDENT 10a. STATE MD 10c. CITY, TOWN OR LOCATION FREDERICK FREDERICK FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 215 THOMAS AVE. 21701 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuban, Mexican, Puerto Ricen, etc.)
1 YES 2 NO Specify: BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Merried ВУ 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EOUCATION (Specify only highest grade completed) 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) ONE PAINTER notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) WALTER WILLIAMS BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 GERALDINE WILLIAMS 215 THOMAS AVE. FREDERICK MD. be 28. METHOD OF DISPOSITION
1-1-1 Burial 2 Cremetion 3 Ref
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of must OATE RESTHAVEN PEMEM. GARDENS! APR examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE GAMEAND COOREST OF THE SAINTS ST. filled in by the traumatic event, the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line. cremation, or IMMEDIATE CAUSE (Final diseese or condition resulting in death) VENTRICULAR FIBRILLATION
DUE TO JOH AS A CONSEQUENCE OF): ysician and completely prior to burial, crematic BOX 68760 OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with aorlic STEMOSIO MEDICAL CERTIFICATION Sequentially list conditions. CONPESTIVE H been signed by the attending physician in the order of Health and Mental Hygiene prior to If any, leeding to immediate DUE TO FOR AS A CONSEQUENCE OF: cause. Enter UNDERLYING CAUSE (Disease or Injury other DIVISION OF VITAL RECORDS, P.O. that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ PHYSICIAN: certificate has be h the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Item HOSPITAL: OTHER: 1 TES 2 NO 1 ☐ Inpatient 2 € ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 8 Other (Specify) marked, or 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT this c 1 Natural
2 Accident 5 Pending 1 YES 2 NO BY After t Investigation 3 Suicide 28e. PLACE OF INJURY — At home, ferm, streel, factory, office building, stc. (Specify) COMPLETED 8 Could not be determined DIRECTOR: / Item 28 is 4 Homicide 29a. CERTIFIER (Check only one)

2 MEDICAL EXAMINER: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(a) end manner os stated. THE FUNERAL C TO THE FUNERAL ( be filed within 72 h HOSPITAL 2 MEDICAL EXAMINER: On the beels 296. SIGNATURE AND TITLE OF CENTIFIES BE 29c. LICENSE NUMBER N WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Prige) 2 30. NAME AND ADDRESS OF PERSON 5 W 9 310

A REGISTRAR'S

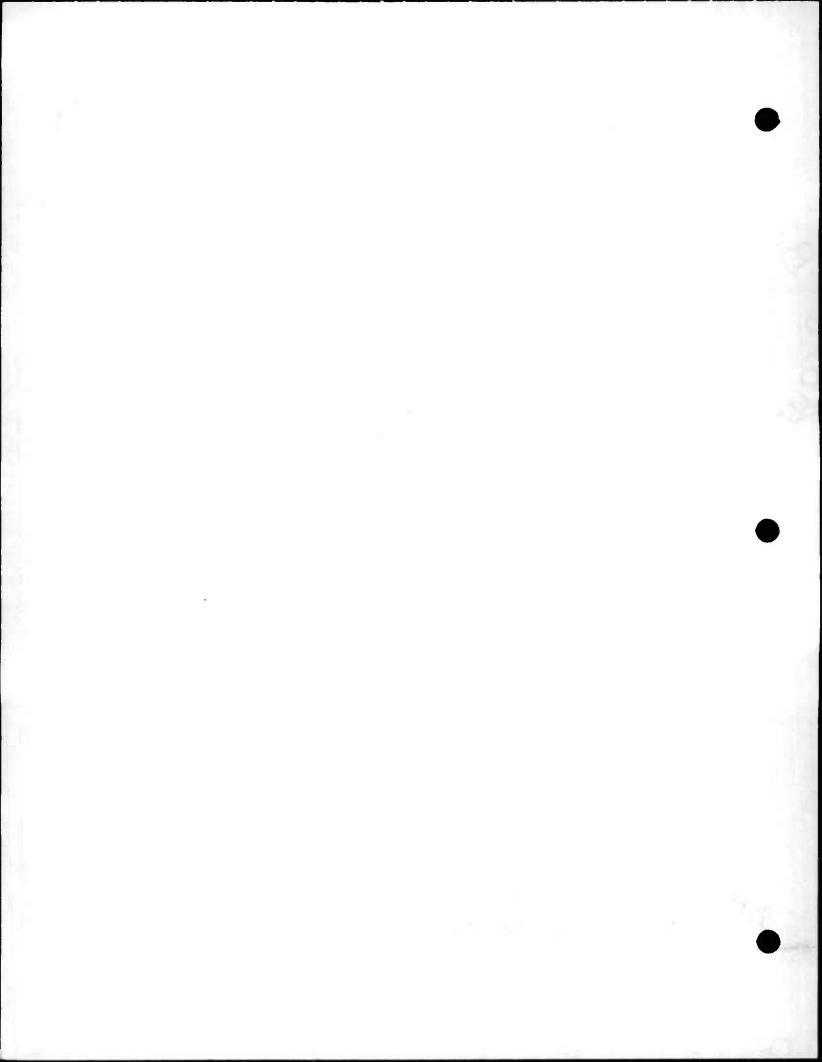
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

FOR STATE REGISTRAR

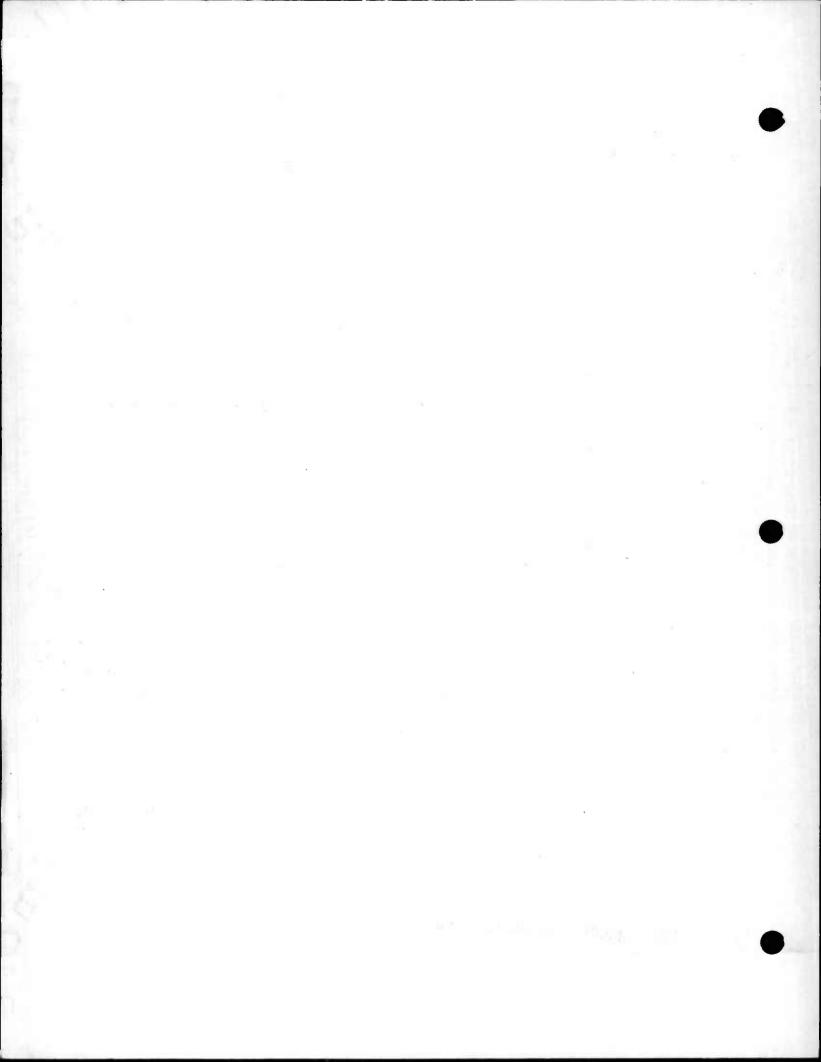
1. DECEDENT'S NAME (First, Middle, Last)

2. DATE OF DEATH 3. TIME OF DEATH 10:37A 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign MÍSSISSIPPI 27 9c. COUNTY OF DEATH FREDERICK 10d. INSIDE CITY YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 14. RACE — American Indian, Black, White, etc. Specify: BLACK 16b. KIND OF BUSINESS/INDUSTRY EASTALCO LAURA WILLIAMS 21701 20c. LOCATION - City or Town, State 28,95 FREDERICK MD HOME FREDERICK MD Approximate Interval Between Onset and Death 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE PERFORMED? 1 TYES 2 NO OF DEATH? 1 YES 2 NO 26d, DESCRIBE HOW INJURY OCCURED 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) stigation, in my opinion, death occured at the time, data end place, end due to the cause(a) and manner as stated. 29d. OATE SIGNED (Month, Day, Year) 28/95 DHMH-16 Rev 1/89



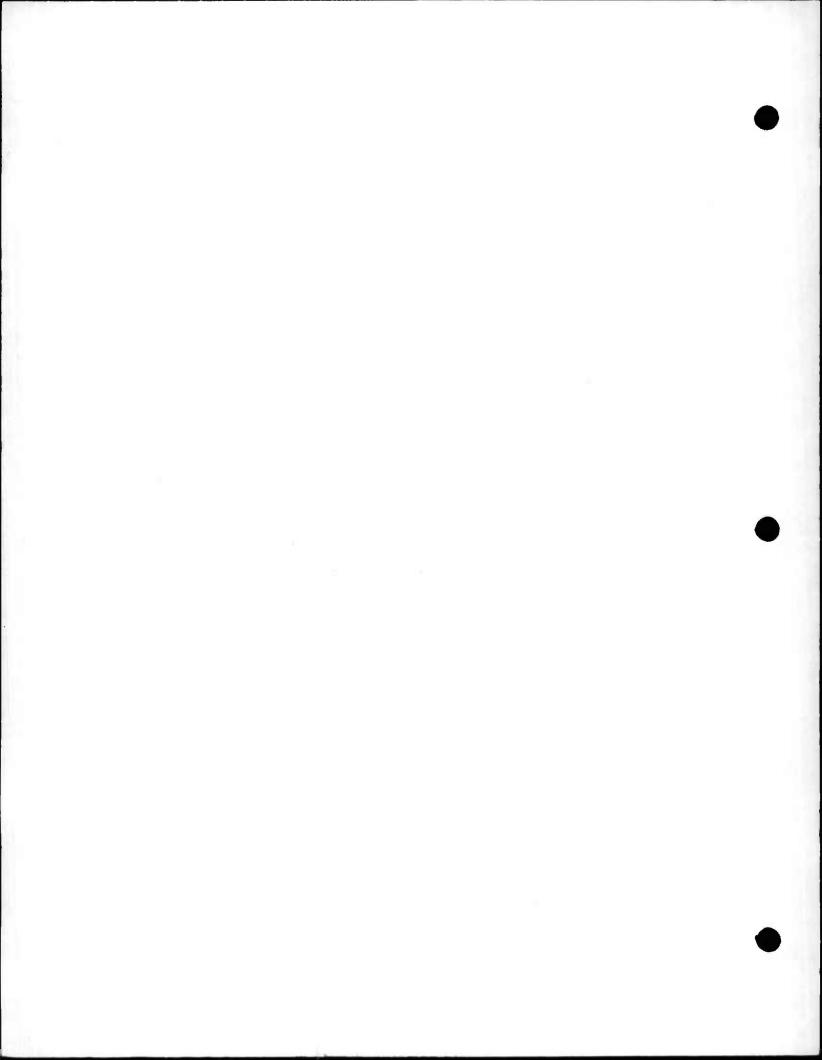
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PHYSICIAN: 1	this certifical	arked, or ite
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ENDING PHYSICIAN: 1	DR: After this certification death with the Sta	Is marked, or ite
ATTENDING PHYSICIAN: 1	ECTOR: After this certifical after death with the Sta	1 28 Is marked, or Ite
OR ATTENDING PHYSICIAN: 1	DIRECTOR: After this certifications after death with the Sta	tem 28 Is marked, or Ite
TAL OR ATTENDING PHYSICIAN: 1	VAL DIRECTOR: After this certifical 72 hours after death with the Sta	If item 28 is marked, or ite
DSPITAL OR ATTENDING PHYSICIAN: 1	INERAL DIRECTOR: After this certification 72 hours after death with the Sta	NT: If item 28 Is marked, or ite
E HOSPITAL OR ATTENDING PHYSICIAN: 1	E FUNERAL DIRECTOR; After this certifical within 72 hours after death with the Sta	RTANT: If item 28 Is marked, or ite
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the ho	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detact to filled within 72 hours after death with the State Clean of Health and Mental Hydlere bride to burial cremation or removal	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	500						9	5 13331			
	1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF FICATE O		MENTAL HYGIEN REG. NO					
	1. DECEDENT'S NAME (First, Middle, Last)						AY	YEAR 3. TIME OF DEATH			
	GEORGE  4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthda	/) IF UNDER 1 YEAR	IF UNDER 24 HRS.	April 2	29,	1995 8:00 P _M			
	216-05-0265  9a. FACILITY NAME (If not institution, give st	1 💢 M 2 🗆 F	86 YRS	MONTHS DAYS	HOURS MIN.	(Month, Day, Year)	1909				
DIRECTOR	6303 W. Furnace B				OR LOCATION OF DE	ATH	9c. cou	onty of DEATH ne Arundel Co.			
EC	10e, STATE 10b. COUNTY			TTY, TOWN OR LO	ATION		10d. INSIDE CITY				
	MD Anne	Arundel Co	). G	len Burr				1 YES 2 NO			
FUNERAL	6303 W. Furnace	Branch Road	3		21061		_	TIZEN OF WHAT COUNTRY?			
5	11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1X YES	N U.S. ARMED			IIC ORIGIN? (Specify Ye	a or No-	14. RACE — American Indian, Black, White, atc.			
B	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR E	PATES		specify Cuben, Maxica ES 2 NO Specify			Specify: Black			
	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECEDENT	'S USUAL OCCUPA of work done during use retired.)	TION most of working	16b. KIND OF BU	SINESS/IN	DUSTRY			
COMPLETED	Elementary/Secondary (0-12) 12th	College (1-4 or 5+)	Electr			THEATE	R &	STAGE			
і ш	17. FATHER'S NAME (First, Middle, Last) George Watty					ME (First, Middle, Maiden					
TO B	19a. INFORMANT'S NAME (Type/Print) Doris M. Streets					Route Number, City or Tow		nie, MD 21061			
	20a, METHOD OF OISPOSITION 1	ovat from State Cer	metery, crematory o	EOF DISPOSITION				- City or Town, State			
	21. SIGNATURE OF FUNERAL SERVICE LICE		Sarrison	Forest	VA Cem.  AND ADDRESS OF FAM		vings	Mills, MD			
	Timet	te fil	Inne	Marc	n Funeral	Home East	n1tiπ	nore, MD 21202			
	23. PART I. Enter/the diseases, or c shock, or heart failure. I	omplications that cause	d the deeth. Do	not enter the r	node of dying, suci	h ss cerdlec or resp	iratory ar	rreet, Approximate			
	IMMEDIATE CAUSE (Final disease or condition reauting in death)	4514	16 1 W	2/20	Disc	as e		Interval Between Onset and Death			
	readiting in beatin)	DUE TO (OR AS	A CONSEQUENCE	OF):	7			3.0			
NO	Sequentially list conditions,	DUE TO (OR AS	A CONSEQUENCE	OFI:	1 196,	von,	a	371			
ICAT	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	Mult.	pte:	مالحه و	000	ecch	4	1, 526 ,			
CERTIFICATION	that initiated events resulting in death) LAST	Malw	CONSEQUENCE	Jean Jean				160			
	PART II. Other significent conditions	contributing to death i	out not reaultin	n the underly	ng ceuse given in	Part i. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS			
PHYSICIAN: MEDICAL	RECURRE	N 261		10/10		PERFOR	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
N	DID TOBACCO USE CONTR	DIRLITE TO CALLEE O	NE DEATH A	/FC FT NO	TUNICEDIAN			1 - YES 2 - NO			
Ā	25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUSE C		TES NO	UNCERTAIN	<u> </u>					
SIC	EXAMINER?	HOSPITAL: 1   Inpetient 2   ER/Out		OTHER:	ome 5 Healdenca	8 Other (Specify)					
	27. MANNER OF DEATH 1 Natural 5 Pending	26e. DATE OF INJURY (Month, Day, Year)		IME OF 28c. I	NJURY AT YORK? YES 2 NO	28d. DESCRIBE HOW I	NJURY OC	CCURED			
ED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spe	f — At home, ferm			26f. LOCATION (Street : City or Town, State)	and Numbe	er or Rural Route Number,			
PLET	29a. CERTIFIER (Check only	CIAN: To the best of my know	rledge, death occu	rred at the time, de	fe and place, and due	to the cause(a) and mar	nner ee ete	ted.			
COMPLET	one) 2 MEDICAL EXAMINER	R: On the basis of examination						the cause(a) and menner as stated.			
TO BE	296 SIGNATURE AND TITLE OF CERTIFIER	Jan South	Sm		29c, LICENSE NUM	53	29d. DAT	TE SIGNED (Month Day, Year)			
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	EATH (ITEM 27) (Ty	pe, Print)	maan	stour	M	and and 21133			
	31. DATE FILED (Month, Day, Year) MAY 0 2 1995	2. REGISTRAR'S SIGN	ATURE				•				
	THE US INTO		-				_	DHMH-16 Rev 1/89			



within at hours after death. Page 6 may be retained by the hospital or attending physician.	ector, page 5 should be detached for use as the burial-transit permit. Pages 1.2.3 should	ath with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
after death	y the fune	TOVAL.	
- hours	filled in b	on, or ren	
withill	Therety	crematic	
YSICIAN: The law requires that the death certificate be executed within	and cor	to burial,	
ificate be	physician	ene prior	
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hat the d	by the	and Mei	
requires t	en signe	of Health	
The law	e has be	te Dept.	-
CIAN: 1	certificat	the Star	
G PHYS	er this	ath with	
ATTENDING PH	TOR: After	be filed within 72 hours after death	
L OR A	L DIREC	hours	
OSPITA	UNERAL	ithin 72	
O THE HOSPITAL OR /	3 THE F	a filed w	
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	1 - FOR STATE REGISTRAR	STATE OF MARY			MENT OF			NTAL HYGIEN	_		
	1. DECEDENT'S NAME (First, Middle, Last)						2	. DATE OF OEATH			3. TIME OF DEATH
	HENRY HUGH	ALEXAND	FR					MONTH D	AY 1	995	12:48 PM
	4. SOCIAL SECURITY NUMBER		(In yrs. les	t birthday)	IF UNDER 1 YEAR	IF UNDER		DATE OF BIRTH			PLACE (State or Foreign
	216-12-3769  9a. FACILITY NAME (If not institution, give st	1 😡 M 2 🗆 F		YRS.	ONTHS DAYS			une 23, 1	_	Pen	nsylvania
œ		/11	0		9b. CITY, TOWI			Н	9c. COU	NTY OF D	EATH
2	Fallston General	Hospital Mi	1ton	Ave.	Fal	lston			Ha	rfor	d
123	10a. STATE 10b. COUNTY			10c, CITY,	TOWN OR LOC	ATION					10d. INSIDE CITY
DIRECTOR	Maryland			Be1							LIMITS?
FUNERAL	100. STREET AND NUMBER 2010 Elm Street				1	101. ZIP CODI			10g. CIT	IZEN OF W	HAT COUNTRY?
						2	1015				
1 <u>5</u>	11. MARITAL STATUS  1 Never Married 2 K Married	12. WAS DECEDENT EVER IN FORCES? 1 1 YES			13. WAS D	ECENDENT C	F HISPANIC	ORIGIN? (Specify Year Puarto Rican, atc.)	or No-	14. RACE	- American Indian, White, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D				8 2 NO		darto riscair, atc.)		Specif	ly:
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	15. DECEDENT'S EDUC (Specify only highest grade	completed)	(G	ive kind of wo	SUAL OCCUPA rk done during i	TION most of working	g	16b. KIND OF BUS	SINESS/INI	DUSTRY	
E E	Elementary/Secondary (0-12)	College (1-4 or 5+)	Wfe.	Do NOT use	retired.)			1			
. B	12	1	E	lectr	onic T	echni	cian	Fed	eral	Gove	ernment
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTI	HER'S NAME	(First, Middle, Maiden	Surname)		
BE	William Alexander	r				M.	abel '	Tepper			
	19a. INFORMANT'S NAME (Type/Print)		191	. MAILING A	ODRESS (Stree			te Number, City or Tow	n, State, Zip	Code)	
유	Evelyn Alexander	2						Air, MD	210		
	20a. METHOD OF DISPOSITION	201	. PLACE		DISPOSITION		, Der			City or Ton	en Siste
	1 Burial 2 Cremation 3 Remo			matory or othe			1			,	
	21. SIGNAFURE ON FUNERAL SERVICE LIC	ENSEE Ronald W	ade.	Dir	22. NAME	AND ADDRES	SS OF FACIL	TY State	Anat	T	2000
	101	I halle	auc,	DII.				blate			
	Jemany//	una						more St.,			MD 21201
	23. PART i. Enter the diseases, or c ahock, or heart failure. I	omplications that cause	d the da	eth. Do no	t antar tha n	ode of dyi	ng, such s	a cerdiac Dr respi	retory ar	rest,	Approximats
	IMMEDIATE CAUSE (Final	Liet only one cause on e	ecn line	٠.	-						intarval Batween Onset and Death
	disesse or condition	Vonto	Meil	our to	=16/11	ation					
	resulting in death)	DUE TO (OR AS	A CONSEC	DUENCE OF):	1911	urion					10 minutes
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CERTIFICATION	Sequentially list conditions, if sny, leading to immediate	DUE TO (OR AS	CONSEC	DUENCE OF):	16/01/	<i></i>	· VO · C/	, c, C			01 110013
5	cause. Enter UNDERLYING	Athom	5/101	mitic	(CIKA	neu	IMSO	dards	MA		11000
Ĕ	CAUSE (Disease or injury that initiated events	DUE TO (OR AS	CONSEC	DUENCE OF):	00 01	1	UUSI	cicer (45)	t uj		19(40)
E	resulting in death) LAST										'
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뒿	PART if. Other significant conditions	contributing to death b	out not r	eaulting in	the undariyi	ng ceuse g	iven in Pa			24b.	WERE AUTOPSY FINDINGS
MEDICAL								PERFOR	NO NO		AVAILABLE PRIOR TO COMPLETION OF CAUSE
								- I I TES 2	KNO		OF DEATH?
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₹	25. WAS CASE REFERRED TO MEDICAL	IDOIL TO CAUSE C	_		(Check only on		CKIAIIY				
PHYSICIAN:	EXAMINER?	HOSPITAL:	cecally.	- 0	THER:						
ž	27. MANNER OF DEATH	1 Inpatient 2/N ER/Out	patient 3					Other (Specify)			
	1 Netural 5 Pending	(Month, Day, Year)		28b. TIME (	ξΥ V	JURY AT	-	d. DESCRIBE HOW II	NJURY OC	CURED	
<b>À</b>	2 Accident Investigation					YES 2	NO				
0	3 Suicida 6 Could not be	28a. PLACE OF INJURY building, atc. (Spec	' — At hor	me, term, atre	eet, factory, off	ca	26	f. LOCATION (Street a City or Town, State)	nd Number	or Rural R	oute Number,
COMPLETED	4 Homicide determined										
<u> </u>	29a. CERTIFIER (Check only	HAN: To the best of my know	ledga, der	nth occurred	at the Jime, da	and place.	and due to	the cause(s) and men	ner sa stat	ted.	
N		t: On the basis of axamination									and munner as stated
	296. SIGNATURE AND TITLE OF CENTIFIER										
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2	TO NAME AND ADDRESS OF DEPOSIT	yuv VIII	_				120	72		>///	4
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEN	(17) (Type, Pr	rint)	0	111	MAN		1	
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	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN		,							
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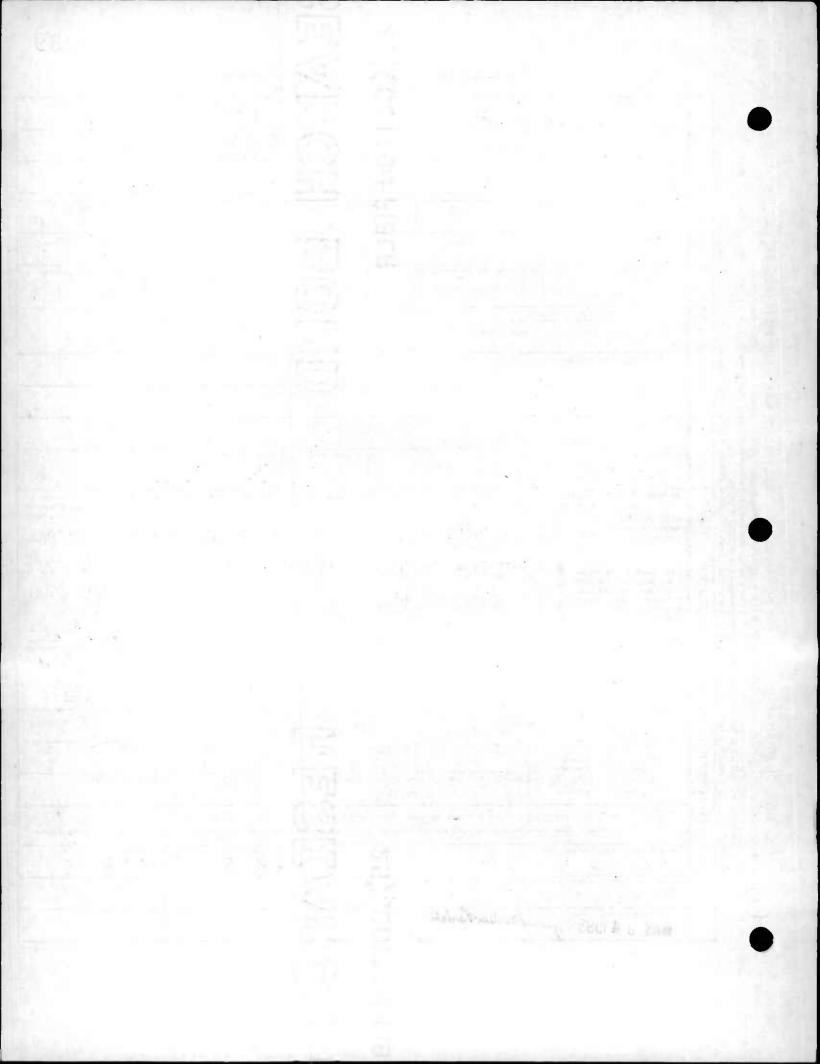
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1. DECEDENT'S NAME (First, Middle, Last, 2. DATE OF DEATH 3. TIME OF DEATN 1995 YEAR Apr 27, 7:50 P. Lockie Victoria Arnett 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 F Jan. 26, 1907 218-28-7135 A 88 N. CAROLINA use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and nu 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR COLTON VILLA NURSING CENTER HAGERSTOWN WASHINGTON RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY MARYLAND WASHINGTON HAGERSTOWN 1 TYES 2 NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 750 Dual Highway 21740 USA 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puarto Ricen, atc.) ti. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indien, Black, White, atc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Merried
3 Widowed 4 Divorced 1 YES 2 XO BY Specify: WHITE COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. OECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) 3 Homemaker Own Home 17. FATNER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) the after death. Page 6 may be retained by William Greer Mattie Cornett BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 2 Paper Mill Rd., Phoenix, MD 21131 Marv M. Wheeler pe 20s METHOD OF DISPOSITION
1 Buriel 2 Cremetion 3 20b. PLACE AND DATE OF DISPOSITION (Name of 28c. LOCATION - City or Town, State must director, tery, crematory or other place)
aney Valley Mem.Gardens MAY Dulaney Timonium, MD examiner 21. SIGNATURE OF FUNERAL SERVICE-DICENSES 22. NAME AND ADDRESS OF FACILITY funeral LOWELL M. Lemmon Funeral Home Lommon the 10 W. Padonia Rd., Timonium, MD 21093 removal medicai Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, 3 Approximata ahock, or heert failure. List only one ceuse on each line. filled in Interval Between 0 **IMMEDIATE CAUSE (Final** Onset and Death npletely fille cremation, event, the ATHEROSCLEROTIC CARDIOVASCULAR DISEASE. diseese or condition resulting in death) SYEARS COM burial, OUE TO (OR AS A CONSEQUENCE OF): OYEARS traumatic CERTIFICATION attending physician and ntal Hygiene prior to bur Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING 5 YEARS PEMENTIA. CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): thet initiated eventa reaulting in death) LAST 6 Mental Health and Men PART II. Other eignificant conditions contributing to deeth but not recuiting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? Shows 1 | YES 2 1 NO Jo. has be Dept. c PHYSICIAN: NIA 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) certificate the the State HOSPITAL: OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) 1 YES 2 NO DR ATTENDING PHYSICIAN: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 6 27. MANNER OF DEATN 28a. OATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? Sc. INJURY AT WORK?

1 YES 2 NO 28d. DESCRIBE NOW INJURY OCCURED this c marked, N/A INJURY 1 Netural 5 Pending Investigation NIA M NIA BY After 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, 8 Could not be determined DIRECTOR: / 69 COMPLETED 4 Homicide 28 NIA MA Hem 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) and menner as stated. FUNERAL within 72 h HOSPITAL = TO THE HOSPITA
TO THE FUNERA
Be filed within 72
IMPORTANT; II 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occured at the lime, data and place, and due 29b. SIGNATURE AND TITLE OF CERTIFIER D28365 29d. DATE SIGNED (Month, Day, Year) 86 28 Law you max 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 368 MILLS STREET. HAGERTOWN THE STEAM THE VALE 31. DATE FILEO (Month, Day, Year)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH
MONTH
APRIL 3. TIME OF DEATH 1800 IF UNDER 1 YEAR | IF UNDER 24 HRS 8. BIRTNPLACE (State or Foreign 233-52-8606 6/6/34 4 1 M 2 □ F 60 DAYS HOURS unk. YRS permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Deaton Medical Center Baltimore, NA RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD NA Baltimore TT YES 2 □ NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? in by the funeral director, page 5 should be detached for use as the burial-transit removal. S. Charles St. 21230 USA Page 6 may be retained by the hospital or attending physician, 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 24 ANO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. It yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES TO NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES SpecifiWhite 3 Widowed 4 Divorced 16e. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16b, KIND OF BUSINESS/INDUSTRY (Specify only E Elementary/Secondary (0-12) College (1-4 or 5+) COMPL unk. NA unk. unk. once. 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Malden Surname) notified at unk. BE unk. 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Nadine Beckett 300 Metro Plaza 3rd fl., Balto., MD 21215 must be 20a. METNOD OF DISPOSITION
1 Burlet 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Mt. Zion 4 Donation 6 Other (Specify) 5/3/95 Lansdowne, MD 22. NAME AND ADDRESS OF FACILITY
Albert P. Wylie
638 N. Gilmor St
Balto. MD 21217 medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Funeral Home, P.A. 23-PART I. Enter the diseases, or emplications that caused the death. Do not anter the mode of dying, such/as cardiac or respiratory arrest, signed by the attending physician and completely filled in by Health and Mental Hygiene prior to burlal, cremation, or remo Approximata shock, or heart failure. List only one cause on each line. intarvai Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition_ phelmania Spiration 5 MILLO reauiting in death) other traumatic event, DUE TO (OR AS A CONSEQUENCE OF): arc moma CERTIFICATION O COLM Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING disere nulmona a homony hmic CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resuiting in death) LAST 1/2 monsim any Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPS: PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL COMPLETION OF CAUSE 1 YES 2 NO Shows 1 YES 2 NO this certificate has been with the State Dept. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL Item 2 28. PLACE OF DEATN (Check only one ITAL OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) OR ATTENDING PHYSICIAN: 1 YES 2 NO petient 2 - ER/Outpetient 3 - DOA 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Oay, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 28 Is marked, 1 Natural DIRECTOR; After the hours after death a 1 YES 2 ND ВУ 2 Acciden Investigation 28a. PLACE OF INJURY — At home, farm, street, tectory, office building, atc. (Specify) 3 Sulcida 261. LOCATION (Street and Number or Rural Route Number, COMPLETED 8 Coyld not be 4 Nomicide If Item 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. THE FUNERAL ( TO THE HOSPITAL TO THE FUNERA be filed within 72 IMPORTANT: II 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE ► 430190 2 30. NAME AND ADDRESS OF PER WND COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 4 seo wikers 31. DATE FILED (Month, Day, Year) 0 4 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

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REG. NO.

			1. DECEDENT'S NAME (First, Middle, Last) CLARA		BLAN	IK		2. DATE OF DEATH DATE OF APRIL 3	. 199r	year 3. TIME OF DEATH 5 4:20am M
			4. SOCIAL SECURITY NUMBER 3380 215-07-2380A		(In yrs. last birthday,	F UNDER 1 YEA		7. DATE OF BIRTH (Month, Day, Year) AUG. 9,1		B. BIRTHPLACE (State or Foreign Country) MARYLAND
Sinche C	,	TOR	9a. FACILITY NAME (If not institution, give s JEWISH CONVALES			9b. CITY, TOW	N OR LOCATION OF DE BALTIMO	EATH		Y OF DEATH BALTIMORE
Dermit Pages		DIRECTOR	10a, STATE 10b, COUNTY MARYLAND N	/A	10c. CI	TY, TOWN OR LO				10d. INSIDE CITY LIMITS? 1 X YES 2 NO
		FUNERAL		RE AVE., APT	703		101. ZIP CODE 2121	5	10g. CITIZE	EN OF WHAT COUNTRY? USA
21215-0020 all or attending physician. for use as the burial-transit		B	11. MARITAL STATUS 1 Never Married 2 Married 3 M Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 TYES IF YES, GIVE WAR OR D	2 NO	If yes	DECENDENT OF HISPAI , specify Cuban, Maxica YES 2 NO Specif		or No- 1-	4. RACE — American Indian, Black, White, etc. Specify: WHITE
		COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(Give kind of life. Do NOT	S USUAL OCCUP work done during use retired.)	ATION most of working	U.S.F.		
MARYLAND 2 retained by the hospital 5 should be detached to		ш	17. FATHER'S NAME (First, Middle, Last) MORRTS	T.	ONG		18. MOTHER'S NA	ME (First, Middle, Malden		ROBINSON
		TO B	190. INFORMANT'S NAME (Type/Print) MRS. SOPHIE	ENOCK		G ADDRESS (Stre				ORE, MD 21215
ORE 6 may ctor, pa	HUS!		20s METHOD OF DISPOSITION  1  Burial 2  Cremation 3  Hern  4  Donation 5  Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LIC	oval from State cer	b. PLACE AND DATE metery, crematory or EBREW YO	other place) DUNG MEN	NS 5-	2+1995 BAL		ly or Town, Stata E, MD
BALTIM after death. Page w the funeral dire	_ 0		Jesluey LX	tellman	ر	SOI 601	O REISTER	& BROS., STOWN ROAD	BALT	IMORE, MD 21215
in 24 hours af			23 PART/I. Enter the diseases, of ahock, or heart failure.  IMMEDIATE CAUSE (Fine disease or condition resulting in death)	a. MAL GMA  DUE TO (OR AS	d the death. Do	not enter tha	mode of dying, suc	has cardiac or respi	PAM	Approximata Interval Batween Onset and Death  MSC 3 Months
68760 xecuted with	- 6	NO	Sequentially list conditions.	b					-11131	TOUR S TOURS
BOX cate be e	traum	CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	с	A CONSEQUENCE (					
S, P.O.	d Mental Hygiene Injury, or other	H	PART II. Other significant condition	d.						
ECORDS, quires that the den signed by the a	amy amy	MEDICAL	TAIL II. Other significant condition	e community to death E	out not resulting	in the underly	/ing cause given in	Part i. 24a. WAS AN PERFOR 1 TYES 2	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
L R law re	23 sh		DID TOBACCO USE CONTI	RIBUTE TO CAUSE C	OF DEATH Y			N D		1 □ YES 2 □ M6
I OF VITAL PHYSICIAN: The law this certificate has	9 g	PHYSICIAN:	EXAMINER?  1   YES 2   NO  27. MANNER OF DEATH	HOSPITAL: 1 Inpatient 2 ER/Out	patient 3 DOA		lome 5 Analdenca			
SION OF TENDING PHYSIC OR: After this cer	marke	BY PI	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) 28e. PLACE OF INJURY	IN	M 1 [	WORK? YES 2 NO	28d, OESCRIBE HOW II		
DIVISION OR ATTENDING DIRECTOR: After		ETED	3 Suicide 6 Could not be determined	building, atc. (Spe	cify)			281. LOCATION (Street a City or Town, State)		
HOSPITAL O	2 =	COMPL		CIAN: To the best of my know  R: On the bests of examination						cause(a) and manner as stated.
뿔 뿔	be filed within	BE	296. SIGNATURE AND TITLE OF BEHTWEE	nolon	MP		29c. LICENSE NUN	10 41)	29d. DATE S	SIGNEO (Month, Day, Year)
11		٩	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Typ	o. Prige)	0 0 0	1.1		1220

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

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9

27. MANNER OF DEATH

5 Pending

29b. SIGNATURE AND TITLE OF CERTIFIEF

Investigation

1 Natural

2 Accident 3 Sulcide

4 Homicide

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be defached for use as the burdal-transit perm	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 Jacqueline I. Banks May 10:15 PM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign May 19, 1933 1 M 2 X F 212-34-3040 61 MD 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 5441 Marsh Hawk Way Columbia Howard RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Howard Columbia 1 TES 2 1 NO 10a STREET AND NUMBER FUNERAL 10f, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5441 Marsh Hawk Way 21045 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—It yes, specify Cuban, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 X Married BY 3 Widowed 4 Divorced Black 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) School Teacher Elementary School 12 4 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Clinton Johnson Irma Wheeler BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) 2 Sylvester T. Banks, Jr. (Spouse) 5441 Marsh Hawk Way, Columbia, MD 21045 20a. METHOD OF DISPOSITION
1 M Burlel 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State cemelery, cremetory or other place) Christ Episcopal Cem. May 5, 1995 Columbia, MD Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Home 5555 Twin Knolls Rd. Columbia, MD 21045 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line. Approximata Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition Metasturite Zyens Gastin Cancer reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS

1 TYES 2 NO

AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN

25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO

1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY

4 Nursing Home 5 Rasidence 6 Other (Specify) 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCUREO

1 YES 2 NO 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify)

28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. (Check only one)

2 MEDICAL EXAMINER: On the bests of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) and menner as stated.

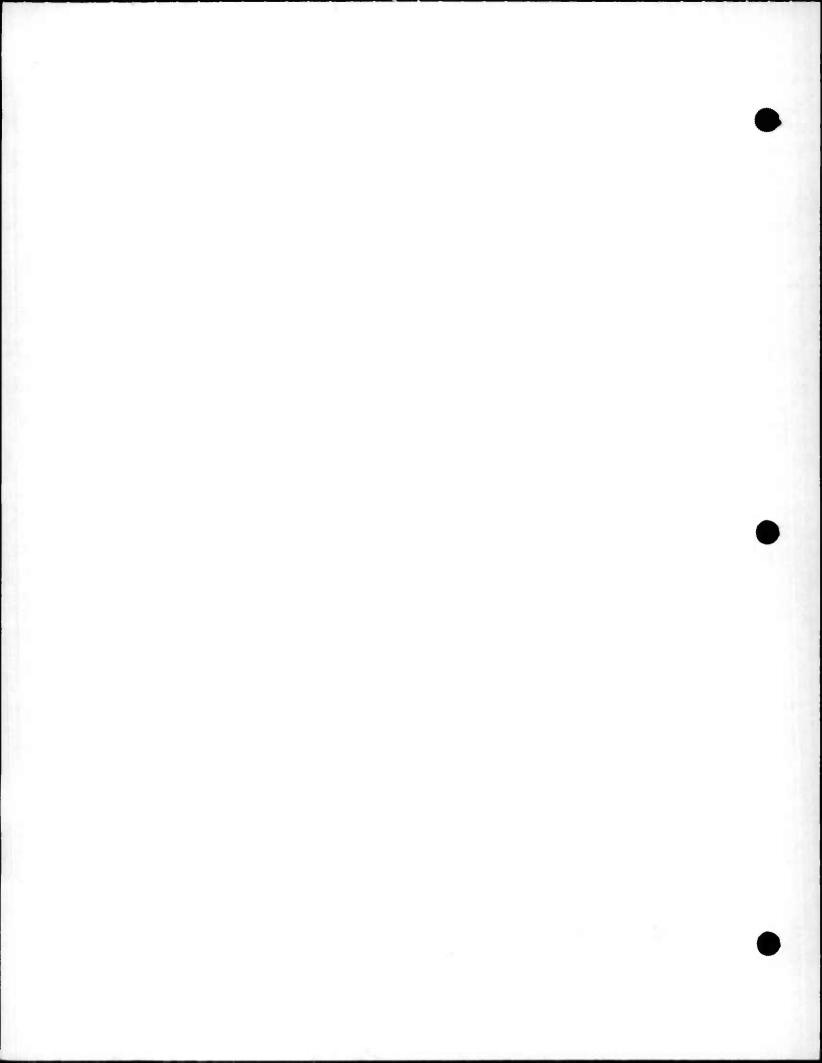
mi

29c. LICENSE NUMBER

29d. OATE SIGNED (Month, Day, Year,

PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 REGISTRAR'S SIGNATURE 31. DATE FILEO (Month, Day, Year) 0 4 1995



	1. DECEDENT'S NAME (First, Middle, La	$\alpha \rightarrow 1$		RTIFICATE OF	DEATH	2. DATE OF DEATH	). 19 9 9 9 6	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		GE (in yrs. last	URRELL				10,33P
	577-32-8923	1 🗆 M 2 📈 F	7.3	YRS. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Dec. 22,	1921 Sou	
æ	9a. FACILITY NAME (If not institution, go	2			OR LOCATION OF		9c. COUNTY OF	DEATH
CTOR	St. Agnes Host			Bg	<u>ltimore</u>	City	N/A	
DIRE	10e. STATE 10b. COL			10c. CITY, TOWN OR LOCA		-		10d. INSIDE CITY LIMITS?
AL D	MARYLAND 100. STREET AND NUMBER	N/A		BALTIMORE	CTTY of ZIP CODE		100 CITIZEN OF	1 X YES 2 NO
100	2550 W. Pratt 9	Street			2122	3		S.A.
BY FUNE	11. MARITAL STATUS  1 Never Merried 2 Married  3 [X] Widowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 YOUR VERY OF	ES 2 XX	O If yes, a	CENDENT OF HISP pecify Cuben, Mexi S 2 X NO Spe	ANIC ORIGIN? (Specify Yelcan, Puarto Ricen, etc.)	s or No- 14. RAG Bie	CE — American Indian, ck, Whita, etc.
	15. DECEDENT'S		16a. DEC	EDENT'S USUAL OCCUPATI	ON	16b. KIND OF BU	SINESS/INDUSTRY	BL.ACK
LET	(Specify only highest gi	College (1-4 or 5+)	(Giv	re kind of work done during m Do NOT use retired.)	ost of working	1000.0000		
COMP	12th grade		Do	omestic			IKNOWN	
_	17. FATHER'S NAME (First, Middle, Last)  Marshall Scott					NAME (First, Middle, Maiden		
BE	19e. INFORMANT'S NAME (Type/Print)		19b.	MAILING ADDRESS (Street	Cloti			
5	Oliver Wanamake	er	1	001 Branch A				nd 20748
	20a. METHOD OF DISPOSITION 1 (X Burlai 2 Cremation 3 D R		20b. PLACE A	NO DATE OF DISPOSITION /	ame of	DATE 20c. LC	OCATION — City or 1	
	4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNEBAC SERVICE	LICENSE	M	t. Zion Ceme	etery	5/6   Ba1	timore,	Maryland
	· 71 900	Geoww		WILLI <i>I</i> 1206	M C. BR W. Nort	OWN COMMUNI h Avenue		
	23. PART I. Enter the diseases, shock, pr heart failu IMMEDIATE CAUSE (Finsi disease or condition resulting in death)	re. List only one ceuse or	n each line.	UENCE OF):		och as cardisc or resp	iratory srrest,	Approximate Interval Between Onset and Dea
		DUE TO (OR A	S A CONSEC	UENCE OF):				
-		CUF		,				750
NOI	Sequentially list conditions, if any, leading to immediate	DUE TO (OR A						75yr
ICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR A HYPER	is a consecutive	UENCE OF):				>5 yr 20 dog
ERTIFI	if any, leading to immediate cause. Enter UNDERLYING	b. OHF	S A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULARIAN A CONSECULAR	UENCE OF):				>5yr 20 dog, >5yr
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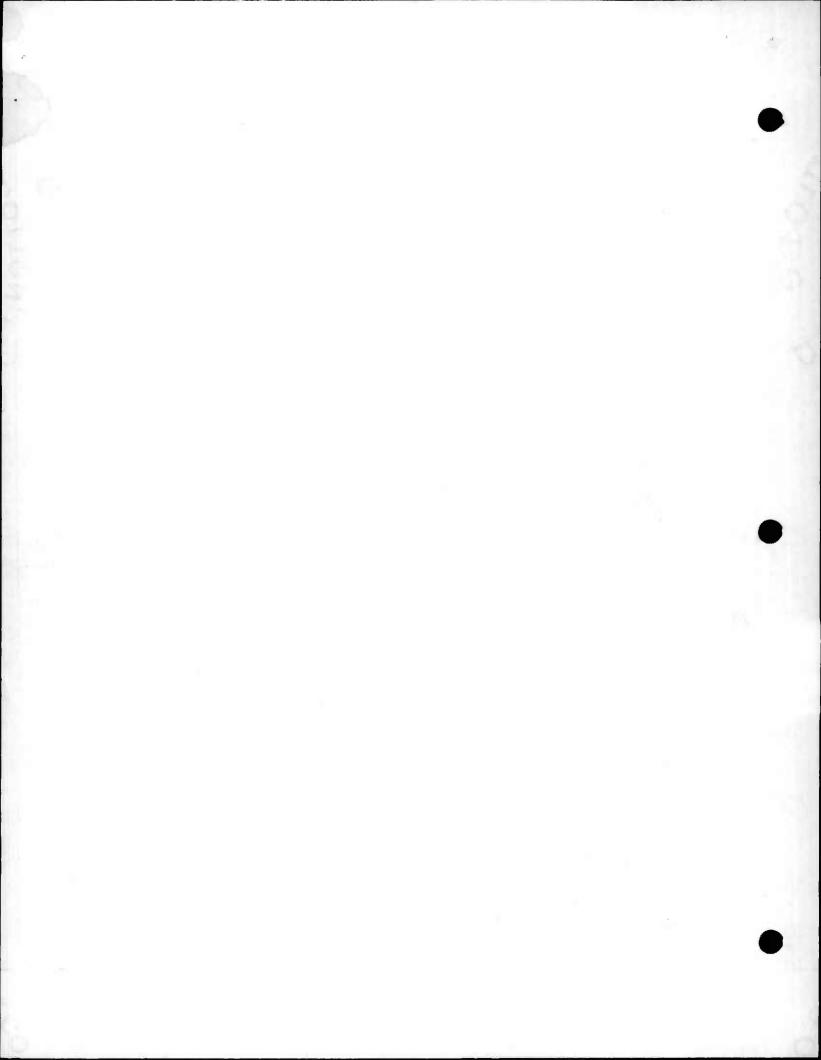
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1. DECEDENT'S NAME (First, Middle, Last)

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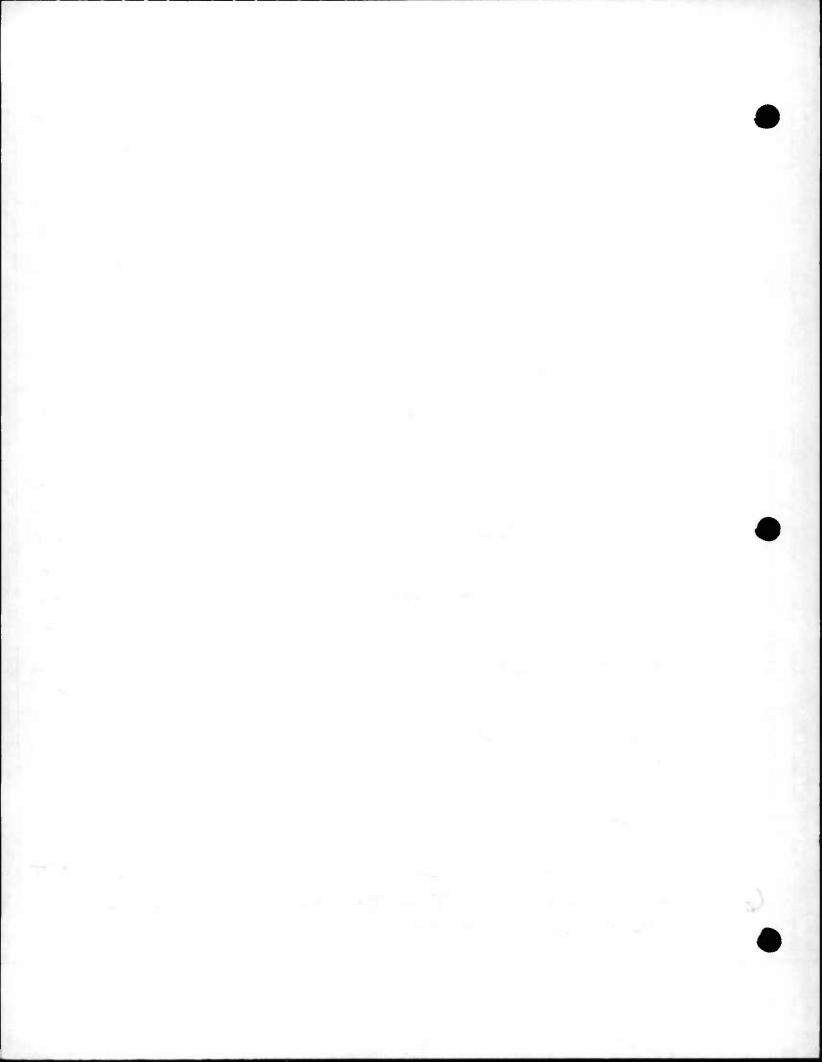
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us aret veati. Fage o may be telained by the hospital of the by the funeral director, page 5 should be detached for removal. removal. edical examiner must be notified at once.	일	Mr. Jack Beaty			196. MAILING									1722
be de		20a. METHOD OF DISPOSITION					_		au		T -			1722
Sirector, pa	1	1 🖹 Burlai 2 🗆 Cremation 3 🗆 Remove 4 🗆 Donation 5 🗆 Other (Specify)	al from State	cemetery,	CEAND DATEO Crematory or oth VIEW	er place)	ON (Nan	ne of	-1-	5/5			City or Town	
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Dept.	AN	DID TOBACCO USE CONTRII	BUTE TO CAUS		ACE OF DEATH			UNC	ERTAIN					
or Item 23	PHYSICIAN:	EXAMINER?	OSPITAL:			OTHER:								
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After death death	ВУ	2 Accident Investigation 3 Suicide & Could not be	28a. PLACE OF IN	JURY — At	home, farm, at	reet, factor		2		28f. LOCATI	ON (Street a	nd Number	or Rural Bou	te Number
ECTOR: A s after de	TED	4 Homicide 8 Could not be detarmined	building, atc.	(Specify)						City or	own, State)	110 11001	or restain riou	io mornos,
FIGST IAL OF ATTENDING THISDURAY, THE AMPLIED FOR WITHIN 72 hours after death with the State Dept. TANT: If Item 28 is marked, or Item 23 s	COMPLET	29a, CERTIFIER (Check only	M: To the best of my	knowledge	doub comme		4.0	-4-1		Sel.				
RAL 172	M	(Check only one) 2 MEDICAL EXAMINER:												nd
TO THE FUNERAL DE filed within 72 IMPORTANT: If		296. SIGNATURE AND TITLE OF CERTIFIER									y prace, an			
TO THE be filed	H	allost on		•				29c. LICE	I L	BER ククル		29d. DATE	SIONED (M	lonth, Day, Year)
<b>≥</b> 6 9 <b>≥</b>	일	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE O	OF DEATH (	TEM 27) (7/00 1	Print)			76	25/			2/	-195
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



DALLIMONE, MARTLAND	ours after death. Page 6 may be retained by the hosp	I in by the funeral director, page 5 should be detached removal.	nedical examinar must be notified at once.
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after drum. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLA		TMENT OF		MENT	REG. NO.	E	
1		2NELL	Cook			2. DA	TE OF DEATH DA	PH	3. TIME OF DEATH ZIOPM
			yrs. last birthday) 7 5 YRS.	MONTHS DAYS		(Me	TE OF BIRTH onth, Day, Year)	- 10	BIRTHPLACE (State or Foreign Country)
	9a. FACILITY NAME (If not institution, give street	21 /	, ,	9b. CITY, TOWN	I OR LOCATION OF		7.7,1919	9c. COUNTY	ARYLAND OF DEATH
OR O	ST. AGNES HOSPITAL			BALT	TIMORE			BAI	LTIMORE CITY
DIRECTOR	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOC	ATION				10d. INSIDE CITY
		BALTIMORE		ARBU	TUS				1 YES 2 X NO
RAL	100. STREET AND NUMBER 1183 CIRCLE DRIVE				IOI. ZIP CODE				OF WHAT COUNTRY?
FUNERAL		2. WAS DECEDENT EVER IN U	U.S. ARMED	13. WAS D	21227		GIN? (Specify Yea		J.S.A.
B	1 Never Married 2 X Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 MNO	If yes,	specify Cuban, Max ES 2 X NO Spe	ican, Puar	to Rican, etc.)		RACE — American Indian, Black, White, alc. Specify: WHITE
E	15. DECEDENT'S EDUCAT (Specify only highest grade con	ION npleted)	16a. DECEDENT'S (Give kind of	work done during i		-	16b, KIND OF BUS	INESS/INDUST	
COMPLETED	Elementary/Secondary (0-12) 12TH GRADE	College (1-4 or 5+)	HOMEM				HOME	MAKING	,
S S	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S	NAME (Firs	t, Middle, Maiden S		
BE (	ELMER F. BURNHARDT						ENE DORR		
2	19a. INFORMANT'S NAME (Type/Print) HENRY E. COOK		19b. MAILING	ADDRESS (Stree	and Number or Run	al Floute No	1-1		
	20a. METHOD OF DISPOSITION 1  Burlel 2  Cremation 3  Removal		PLACE AND DATE			I D		ATION - City	or Town, Slata
	4 Donation 6 Other (Specify)	TO	ŰĎŐŇ PA			5/		TIMORE	
	21. SIGNATURE OF FUNERAL SERVICE LICENS	- NI ~		HUBB	ARD FUNE	RAL			
	23. PART I. Enter the diseases, or com	pilcations that ceused i	tha death. Do r		WILKENS				
	shock, or heart feliure. List iMMEDIATE CAUSE (Final disease or condition resulting in death)		410 74150						Onset and Death
	a	SOUS TO (OR AS A C	CONSEQUENCE OF	F):					, ace
NO	Sequentially list conditions, b.	Leuce De	CONSEQUENCE OF	F):					days
CERTIFICATION	if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury	Chemo	therce	PY					2 aks
	that initieted events resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF	h: /					10111
	d	Lymph	oma						10yrs
CAL	PART II. Other aignificant conditions of	ontributing to death but	not resulting	in the underlyi	ng ceuse given i	n Part i.	24a. WAS AN / PERFORE		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
	right ingrotell	>14					1 - YES 3	100	COMPLETION OF CAUSE DF DEATH?
N N	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF	DEATH YE	S NO I	UNCERTA	JN 🗆			1 - YES 2 200
PHYSICIAN: MED	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	. PLACE OF DEAT	TH (Check only on OTHER:	9)				
HASI	1 YES 2 YOO 1	☐ Inpatient 2 ER/Outpet	ient 3 DOA	4 - Nursing Ho	ma 5 Residence				
BY PI	1 Natural 5 Pending	(Month, Day, Year)		URY	ORK?	260. 0	PESCRIBE HOW IN	JURY OCCURI	
	2 Accident Investigation 3 Suicide 6 Could not be determined	26a. PLACE OF INJURY — building, atc. (Specify	At home, farm,	street, factory, off	ica	26f. L	OCATION (Street ar	nd Number or F	tural Route Number,
COMPLETED	29e. CERTIFIER 1 CERTIFYING PHYSICIAL	N: To the best of my knowled	ion death occurre	ad at the time de	to and plane and d	on to the	(-)(		
S I	(Check only one) 2 MEDICAL EXAMINER: 0	In the besis of examination a	and/or investigation	n, in my opinion,	death occured at ti	ne time, d	ete and place, and	dua to the ca	use(s) and manner as stated.
BEC	296 SIGNATURE AND TITLE OF CERTIFICAL				29c. LICENSE N	UMBER		29d. DATE SIG	GNED (Month, Day, Year)
10	30. NAME AND ADDRESS OF PERSON WHO CO	mely W	10		D183	-81	7	Ma	42 1995
	Mer GORME	toly 90	D CA	TON ,	Avs	BA.	Lyo 1	MA	21229
	MAY 0 4 1995	32 REGISTRANS SIGNA							



blh FOR STATE

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-723 5/8/95 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFI	CALE OF	DEATH	P	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF	DEATH		3	. TIME OF DEATH
	Joseph	Vincent	Cr	ocetti		Apri	DAY	1995	AR	2013 M
	4. SOCIAL SECURITY NUMBER		GE (In yrs. lest birthday)	IF UNDER 1 YEAR		7. DATE OF I				
	220-88-6548	1 X M 2 □ F 2		MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	(Month, De	HFTTH Y, Yba <i>r</i> )	8.	BIRTHPL Country)	ACE (State or Foreign
			O YHS.			NOV.22	,196	8	MAR	YLAND
	9e. FACILITY NAME (If not institution, give a	street and number)		9b. CITY, TOWN	OR LOCATION OF DE	EATH		9c. COUNTY	OF DEA	TH
9	St. Agnes Hosp	oital		Balti	more			RΛ	TTT	MORE CITY
DIRECTOR	RESIDENCE OF DECEDENT							DA	TITI	MOKE CITY
2	10a. STATE 10b. COUNT	¥	10c. CITY,	TOWN OR LOCA	TION		_		10	Od. INSIDE CITY
	MARYLAND BAL	TIMORE CITY	′	BALTIMO	DRE				10	X YES 2 NO
7	10s. STREET AND NUMBER			10	f. ZIP CODE			10a CITIZEN		AT COUNTRY?
FUNERAL	600 LUCIA AVENUE	1			21229					U COOKINII
Z	11. MARITAL STATUS							U.S	-	
5	1 Never Married 2 Merried	12. WAS DECEDENT EVE FORCES? 1 Y	ES 2 X NO	13. WAS OF	CENDENT OF HISPAN ecity Cubers, Mexica	VIC ORIGIN? (S	secify Yes	or No- 14.	RACE -	- American Indian, White, etc.
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OF	ROATES	1 TYES	2 NO Specify	y:	,,	1	Specify:	
										WHITE
COMPLETED	15. DECEDENT'S EOU (Specify only highest grade	CATION completed)	16a, DECEDENT'S U	SUAL OCCUPATI	ON set of working	16b. KIN	D OF BUSI	NESS/INDUST	RY	
W	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT use	retired.)	at or working					
린	12TH GRADE		NEVE	R WORKI	ED		DISA	BLED		
ő I	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME /First Middle	Maiden S	(emama)		
	JOSEPH CROCETTI				FRANCES			,		
띪	19e. INFORMANT'S NAME (Type/Print)									
임		mm T	196. MAILING A	ADDRESS (Street	and Number or Rural I	Route Number, C	ity or Town,	State, Zip Coo	fe)	
	FRANCES C. CROCE	TTI	600 F0	CIA AVI	NUE - BA	LTIMOR	E, MI	) 21	229	
	20e. METHOD OF DISPOSITION 1    Burlel 2 □ Cremation 3 □ Rem		20b. PLACE AND DATE OF		ame of	DATE	20c. LOCA	ATION City	or Town	State
	4 Donation 5 Other (Specify)	DAMI (LOW 2000)	cemetery, crematory or other LAKEVIEW		T DADY	5/2	CVI	KESVIL	TE	9.0000
	21. SIGNATURE OF FUNERAL SERVICE LIC	DENSEE	DARKE V I DW		ND ADDRESS OF FAI		311	CESATE	LE	
- 1	No.	50 K	1,01		D FUNERA		INC.			
	Isuse	C/	and the		ILKENS A				MD	21220
	23. PART i. Enter the diseases, or o	complications that ceu	sed the death. Do no	t enter the mo	de of dving, auci	h as cerdisc	or respire	tory arrest	1110	Approximate
	anock, or neart feiture.	List only one cause or	eech ilne.							Interval Between
	iMMEDIATE CAUSE (Final disease or condition									Onset and Death
- 1	resulting in death)		NTOXICATION							
1	1	DUE TO (OR A	S A CONSEQUENCE OF):							
Z	a light and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the st	b								
≌ II	Sequentially list conditions, if any, leading to immediate	DUE TO (OR A	S A CONSEQUENCE OF):							
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury	c.								
	thet initiated events	DUE TO (OR A	S A CONSEQUENCE OF):		<del></del>					
문	resulting in death) LAST									
ш										
ᄗᅦ		d								
	PART II. Other algnificent condition	s contributing to deeth	but not resulting in	the underlyin	g ceuse given in	Part I. 24a	WAS AN A		24b. WI	FRE AUTOPSY FINDINGS
	PART II. Other algnificent condition	s contributing to deet	but not resulting in	the underlyin	g ceuse given in		PERFORM	ED?	AV	ERE AUTOPSY FINDINGS AILABLE PRIOR TO AMPLETION OF CAME
EDICAL	PART II. Other algnificent condition	d	n but not resulting in	the underlyin	g ceuse given in			ED?	OF	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
MEDICAL						_ יצי	PERFORM	ED?	OF	MILABLE PRIOR TO OMPLETION OF CAUSE
MEDICAL	DID TOBACCO USE CONTR		OF DEATH YES	□ NO □		_ יצי	PERFORM	ED?	OF	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
MEDICAL		RIBUTE TO CAUSE	OF DEATH YES	O NO [		_ יצי	PERFORM	ED?	OF	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
MEDICAL	DID TOBACCO USE CONTI		OF DEATH YES	OTHER:	] UNCERTAIN	1/2	PERFORM VES 2	ED?	OF	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
MEDICAL	DID TOBACCO USE CONTS 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	RIBUTE TO CAUSE  HOSPITAL: 1   Inpetient 2   ER/O	OF DEATH YES  26. PLACE OF DEATH  unipatient 3 □ DOA 4	OTHER:	UNCERTAIN  5 □ Residence	1 j	PERFORM VES 2 [	ED?	AM OC OF	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTS 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 XES 2 NO  27. MANNER OF DEATH  1 Netural 5 Pending	RIBUTE TO CAUSE  HOSPITAL: 1   Inpetient 2   ER/O  26e. DATE OF INJUR (Month, Day, Yea.	OF DEATH YES  26. PLACE OF DEATH  Introduction 3 □ DOA 4  W 28b, Time  7 28b, Time  7 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(Check only one)  OTHER:    Nursing Hor	UNCERTAIN  5 - Residence URY AT RICY	6 Other (Spot	PERFORM VES 2 [  city) E HOW INJ	ED?	AM OC OF	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONTI	RIBUTE TO CAUSE  HOSPITAL: 1   Inpetiant 2 X ERVO  26e. DATE OF INJUR (Month, Day, Yea FOUND: 4-28	OF DEATH YES  26. PLACE OF DEATH  unipationt 3 □ DOA (1)  YY 28b, Time (1) 7:25 P	(Check only one) OTHER:   Nursing Hom RY M 1	UNCERTAIN  5 Gesidence  URY AT  RK7  (ES 2 KNO	6 Other (Spi 28d. DESCRIE UNK NOV	PERFORM VES 2 [ city) E HOW INJ	ED?	AM COC OF	AILABLE PRIOR TO DIMPLETION OF CAUSE F DEATH?  Yes 2 \( \text{ NO} \)
BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONTR  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  XES 2 NO  27. MANNER OF DEATH  1  Netural 5 Pending Investigation  3  Suicide 6/X Could not be	RIBUTE TO CAUSE  HOSPITAL: 1   Inpetiant 2 X ERVO  26e. DATE OF INJUR (Month, Day, Yea FOUND: 4-28	OF DEATH YES  28. PLACE OF DEATH  unipations 3 DOA 4  "" 286, TIME " 10 PNUF  B-95 7:25 P  RY - At home, form, str	(Check only one) OTHER:   Nursing Hom RY M 1	UNCERTAIN  5 Gesidence  URY AT  RK7  (ES 2 KNO	6 Other (Spot	PERFORM YES 2 [  ocity) E HOW INJ	IURY OCCURE	AM OCC OF	AMLABLE PRIOR TO MPLETION OF CAUSE F DEATH?  K YES 2 NO
BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  X'ES 2  NO  27. MANNER OF DEATH  1  Natural 5  Pending 2  Accident Investigation	RIBUTE TO CAUSE  HOSPITAL:  1   Inpettent 2   ER/O  28e. DATE OF INJUR (Month, Day, Yea.  FOUND: 4-28  28e. PLACE OF INJUR	OF DEATH YES  28. PLACE OF DEATH  unipations 3 DOA 4  "" 286, TIME " 10 PNUF  B-95 7:25 P  RY - At home, form, str	OF Zec. IN. WY M 1 Check only one)  OF Zec. IN. WY M 1 Check only one)	UNCERTAIN  5 Gesidence  URY AT  RK7  (ES 2 KNO	6 Other (Sp. 28d, DESCRIE UNK NO) 281. LOCATION	PERFORM YES 2 [  HOW INJ  A (Street annum, State)	ED?  NO  URY OCCURE	AM OCC OF	AILABLE PRIOR TO DIMPLETION OF CAUSE F DEATH?  Yes 2 \( \text{ NO} \)
BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONTI	RIBUTE TO CAUSE  HOSPITAL: 1 Inpettent 2 X ER/O  26e. DATE OF INJUR (Month, Day, Yea. FOUND: 4-28  28e. PLACE OF INJUR building, atc. (S)	OF DEATH YES  28. PLACE OF DEATH  surpetient 3 DOA 4  17 286, TIME 17 7:25 P  RY — At home, ferm, str  pecify)  FOUND:	OF ACTION OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF STATE OF	UNCERTAIN  5 G Residence UNIVAT UNIVAT (ES 2 MNO	6 Other (Spot 2ed. DESCRIBE UNK NOV 281. LOCATION City or Too BALTIMO	PERFORM  YES 2 [  HOW INJ  (Street annum, State)  RE CI	NO NO NUMBER OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PROPERTY OF REAL PR	AM OCC OF	AMLABLE PRIOR TO MPLETION OF CAUSE F DEATH?  K YES 2 NO
BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONTI	RIBUTE TO CAUSE  HOSPITAL: 1 Inpetient 2 M ER/O  28e. DATE OF INJUR (Month, Day, Yea FOUND: 4-28  28e. PLACE OF INJUR building, etc. (S)	OF DEATH YES  28. PLACE OF DEATH purpetient 3 □ DOA   28. TIME 17   28. TIME 17   28. TIME 17   7:25 P  IRY — At home, term, stripecify)  FOUND: owledge, death occurred	(Check only one) OTHER:   Nursing Hon RY M 26c. IN, WC 1   HOME	UNCERTAIN  5   Residence UNY AT RK7 /ES 2 NO  end place, end due	6 Other (Son 28d, DESCRIE UNKNOW) 281. LOCATION City or To BALTIMO to the cause(s)	PERFORM  VYES 2 [  VCHy)  E HOW INJ  I (Street annum, State)  PRE CI  end mannum	NO NO NO NO NO NO NO NO NO NO NO NO NO N	OF 1/2	ANLABLE PRIOR TO MPLETION OF CAUSE F DEATH?  K YES 2 NO  PO Number, VENUE
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

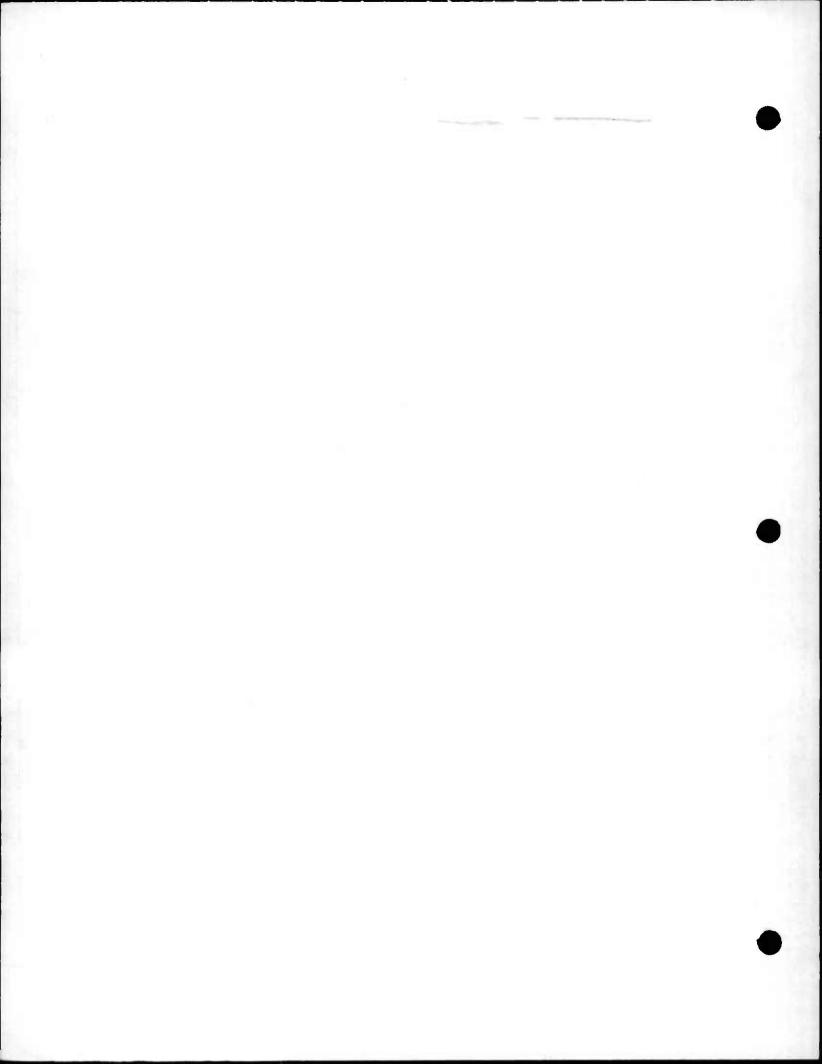
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 3-10103E 05 01 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Morth, Day, Year) Apr. 26,1914 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign 1 M 2 TYP DAVE HOURS 239-24-4559 81 YRS. North Cardina Apr. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Johns Hopkins Bayview Med.Ctr. BAltimore DIRECTOR N/A RESIDENCE OF DECEDENT 10a STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Baltimore ¥ YES 2 □ NO permit. FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10a, CITIZEN OF WNAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 2117 Sinclair Lane 21213 U.S.A. hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 27 NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECEMBENT OF NISPANIC ORIGIN? (Specify Yea or Noif yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 nelfy Cub 1 Never Married 2 Married 1 TYES 2 XNO BY Specify 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY intary/Secondary (0-12) College (1-4 or 5+) 12 Cashier Shoe Company 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 75 Unknown BE UnKnown notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Deborah McCarthy 953 Sandalwood Rd., Essex, Md. 21221 90 20a. METNOD OF DISPOSITION 20c. LOCATION - City or Town, Stata 20b. PLACE AND DATE OF DISPOSITION (Name of must 208. METHOD OF DISPOSITION

1 Surial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Oak Lawn Cemetery 5-5-95 Baltimore, Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Moran-Ashton Funeral Home, Inc. 184 GC 3000 E. Baltimore St., Balto., Md.21224 May signed by the attending physician and completely filled in by the Health and Mental Hygiene prior to burial, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate shock, or heart feiture. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Final **Onset and Death** event, the disease or condition ASTROINTESTINAL BLEED 2da resulting in death) executed within DUE TO (OR AS A CONSEQUENCE OF): other traumatic CERTIFICATION Sequentially list conditions, DUE TO JOR AS A CONSEQUENCE OF if any, leeding to immediate cause. Enter UNDERLYING **CAUSE** (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? any 1 TYES 2 NO shows a 1 TYES 2 NO t, of h PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \( \square\) NO \( \square\) UNCERTAIN certificate has be WE 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) The OSPITAL: Vinpatient 2 ER/Outpatient 3 DOA OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) 1 YES 2 NO OR ATTENDING PHYSICIAN: marked, 27, MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28a. DATE OF INJURY this c 28d. DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident 5 Pending 1 YES 2 NO BY After Investigation 26s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 28 is 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be DIRECTOR: / COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL O
TO THE FUNERAL D
Be filed within 72 ho
IMPORTANT: If Ite MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 94011 M.D. WHO COMPLETED CAUSE OF DEATH (ITEM 27) (1900, Print)
15 RS. M.O. 49 40 Eastern Ave Baltimore HI 21224 2 GLEN MEYERS, M.D 31. DATE FILED (Month, Day, Year) hi Revoluer Randall 04 MAY

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending phy	TO THE FUNRAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bur	be filed within 72 hours after death with the state Dept, of Health and Merital Hydrene prior to bunal, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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2	2	e	¥

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	1 - FOR STATE REGISTRAR	STATE OF MARY	AND / DEPART	MENT OF I	HEALTH AND	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)	P RON	SIDINE			2. DATE OF DEATH MONTH		3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER			F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		5 107 pm
	117-09-2703	1 🕅 M 2 🗆 F		ONTHS DAYS	HOURS MIN.	(Month, Day, Year) 02-10-17		BIRTHPLACE (State of foreign
	9s. FACILITY NAME (If not institution, give s	treet end number)	9	b. CITY, TOWN	OR LOCATION OF DI		9c. COUNTY	ew York
OR	Good Samaritan H	osp. 5601Loc	k Raven	Baltim	ore			
DIRECTOR	RESIDENCE OF DECEDENT  10e, STATE  10b, COUNTY	,	I soo CITY	TOWN OR LOCA				
OIR	Maryland			imore	INON			10d. INSIDE CITY
	10e. STREET AND NUMBER		Dali		f. ZIP CODE		10n. CITIZEN	1 YES 2 NO
FUNERAL	6706 Glenkirk Roa	ad			21239		log. Gillesi	or what cooking
S	11. MARITAL STATUS	12. WAS DECEDENT EVER	N U.S. ARMED	13. WAS DE	ENDENT OF HISPAN	NIC ORIGIN? (Specify Ye	or No- 14.	RACE — American Indian, Black, White, atc.
ВУ Е	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 L NO		ecify Cuban, Mexica 2 NO Specify	in, Puarto Rican, etc.)		Black, White, atc.  Specify:
	15. DECEDENT'S EDU-	CATION	40. 00000000000000000000000000000000000					white
ETE	(Specify only highest grade Elementary/Secondary (0-12)	completed)	16a. DECEDENT'S US (Give kind of wor life. Do NOT use r	RUAL OCCUPATI It done during mo etired.)	ost of working	16b. KIND OF BU	SINESS/INDUST	RY
필	12	College (1-4 or 5+)	Store	salesm	nan	wholes	ale nri	nting paper
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		55010	ourco.		ME (First, Middle, Maiden		neing paper
BE C	Thomas Philip Co	nsidine			Marga	ret Walsh	,	
TO E	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AL	ODRESS (Street )	and Number or Rural I	Route Number, City or Tow	n, State, Zip Coo	(e)
-	Marilee Considine	2	6706 G1	.enkirk	Road, B	altimore,	MD 212	239
	20a. METHOD OF DISPOSITION  1		p. PLACE AND DATE OF one lary, crematory or other		ame of	DATE 20c. LC	CATION — City	or Town, Stata
	21. SIGNATURE OF FUNE AL SERVICE LIC	Ronald T	Wade, Dir.		est Balt	State		ny Board
70	23 PART I. Enter the diseases, or c	omplications that cause	d the death. Do not					
	shock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition	ciat only one cause on a	ach line.				, , , , , , , , , , , , , , , , , , , ,	interval Between Onset and Death
	resulting in death)	DUE TO (OR AS	mic h	ear	asse	ease		
7		Control on Asi	A CONSEQUENCE OF):	there	ule			
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):	,		an		
<u>₹</u>	cause. Enter UNDERLYING CAUSE (Disease or Injury	B						
TE	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):					
	Tooling in county Excit	1						
AL C	PART II. Other significant condition	a contributing to death b	out not reaulting in t	the underlyin	g cause given in	Pert I. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICAL	Peripher	al vasca	lan o	Li sea	e_	PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE
ME								OF DEATH?
ä	DID TOBACCO USE CONTR	RIBUTE TO CAUSE O	F DEATH YES	□ NO □	UNCERTAIN	10		
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	Check only one)				
YSI	1 YES 2 NO	1 Inpetient 2 ER/Outp		☐ Nursing Hom	e 5 🗆 Rasidenca	6 Other (Specify)		
	27. MANNER OF DEATH  1 Natural 5 Pending	(Month, Day, Year)	26b. TIME O	Y WO	RK?	28d. DEŞCRIBE HOW I	NJURY OCCURE	0
BY	2 Accident Investigation	28s. PLACE OF INJURY	- At home term		YES 2 NO	004 LOOATION (0)		
9	4 Homicide 8 Could not be determined	building, etc. (Spec	cify)	et, rectory, offic		28t. LOCATION (Street in City or Yown, State)	ing Number or Ri	urai noute Number,
PE	290. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my know	ledge, death occurred a	it the time, data	and place, and due	to the cause(s) and mar	ner es stated	
COMPLET	one) 2 MEDICAL EXAMINE	R: On the basis of examination	n and/or investigation, i	n my opinion, d	eath occured at the	time, data and place, an	d dua to the cau	use(s) and menner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUM			NED (Month, Day, Year)
O BE	Howard	Sterne			D384	-03		28-95
Ĕ	30 NAME AND ADDRESS OF PERSON WHO	COMPLETED CALLES OF DE	ATIL 07770 07 07 07					/ 5

HO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

AC (HE STO)

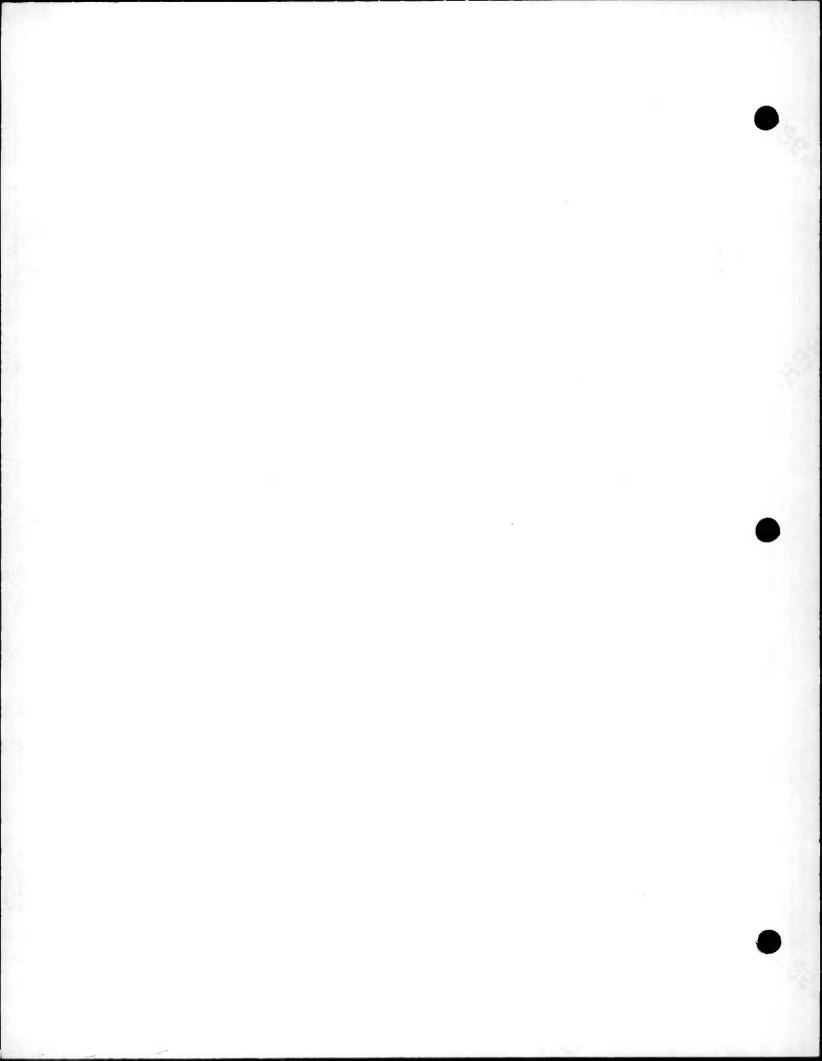
32. REGISTRAR'S SIGNATURE

Howard

MAY 0 4 1995

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Ba ( to 21239



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with amount UNERAL DIRECTOR. After this certificate bethe solined by the attending physician and completely filled itthin 72 hours after death with the State Dept. of Health and Mental Hygene prior to burial, cremation, or ANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the me	F F E SW
after death. Page 6 may be retained by the hospital or attend in by the funeral director, page 5 should be detached for use as indical examiner must be notified at once.	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with an incomplete of the function of the hospital or attending physician.  TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a testing physician and completely filled in by the funeral director, page 5 should be detached for use as the burlar-transit permit. Pages 1, 2, 3 should be filled with rep State Day, or Health and Mental Hygiene prior to burlar, cremation, or removal.  IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
- E	E HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

1	FOR	H. FIL												10013
	1 - STATE REGISTRAR		STATE OF I	VIARYLAI	ND / DEP/ CERTI						<b>HYGIEN</b> REG. NO			
	t. DECEDENT'S NAME (First,	, Middle, Last)								2. DATE OF	OEATH			3. TIME OF OEATH
	SADYE		AHNE	CHI	ESUC	OCK				APR	APRIL 30 1995 4			430 AM
	4. SOCIAL SECURITY NUMB 213-34-14]		5. SEX	6. AGE (In )	yrs. last birthda	MONTHS	DAYS	HOURS	MIN.	7. DATE OF (Month, D	BIRTH (5°, 1	006	Count	HPLACE (State or Foreign
	9a. FACILITY NAME (If not in		- 3	03	) The		Y, TOWN	OR LOCAT	ON OF DE		5,1	-	MTY OF D	RYLAND
<u>ا</u> ا	KESWICJ NU					35. OI	1, 10411	JN LOCAL		TIMORE	2		/A	EAIH
5	RESIDENCE OF DEC	10b, COUNT												
DIRECTOR	MARYLAND	IOB. COOM I	BALTIMOF	?E	10c. (	AIT, TOWN		TIMO:	DE					10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER		Di III I I I I I I					. ZIP COO		_	_	10g. CIT	IZEN OF V	1 TYES 2 X NO
FUNERAL	7 SLADE AVE., APT. 316								2120	08			US	SA
5	11. MARITAL STATUS 1 Never Married 2 Married FORCES? 1 YES			T EVER IN U	S. ARMEO	13	WAS DEC	ENDENT	OF HISPAN	NIC ORIGIN? (	Specify Yes	or No-	14. RACI	E — American Indian, k, White, etc.
B	3			WAR OR DATE								Spec		
B	15. DEC	EDENT'S EDU y highest grade	CATION completed)	10	6a. DECEDENT	'S USUAL of work done	OCCUPATION	ON .		16b. KI	ND OF BUS	SINESS/IN	DUSTRY	
9	Elementary/Secondary (0		College (1-4 or 5	+)	life. Do NO	use retired.	)	IST OF WORK	ng					
COMPLET	12 17. FATHER'S NAME (First, M	iddle ( not)				0	WNER				LOTH		-	
	HARRY	rodie, Lasty	DZ	HNE						ME (First, Mide UDE GA		,		
) BE	19a. INFORMANT'S NAME (7)	ype/Print)		1111411	19b. MAILI	NG ADDRES	SS (Street a			Route Number,			p Code)	
٩	MARTIN D.	COHEN			8510	TOP	PING	ROA	D BAI	LTIMOR	E, M	D 21:	208	
	III 1 □ ❤ Puriet 2 □ Cremation 3 □ Removal from State   cemeter				LACE AND DAT	r other place	1			OATE		CATION -		
	4 Donetion 5 Other  21. SIGNATURE OF: FUNERAL		CENSEE _	AR	LINGTO	N-CH	IZUK			<u>-2-199</u>	5 BA	LTIM	ORE,	MD
	· hall	201	C74			"	SOL	LEV:	INSON	N & BR				
	23. PART I. Enter the di	77/10	ume	h	be death D		601	O RE	ISTE	RSTOWN	ROAL	D BAI	TIM	
	snock, or no	eert fellure.	List only one ceu	se on eecl	h line.	not ente	r the mo	de or dy	ing, auci	n ee cerdled	or reepi	ratory ar	rest,	Approximsta Intervel Between
	disease or condition adducted and a data and a				den	rent	ia							Onset and Death
	disease or condition resulting in deeth)  Due to (or as a consequence of):  Hyperkasive Cardiavascular clusease									12940				
NO N	DIF TO OR AS A CONSEQUENCE OF													
ATI	If any, leeding to immediate cause. Enter UNDERLYING													
Ĕ	CAUSE (Disease or inju that initieted events		DUE TO	(OR AS A CO	ONSEQUENCE	OF):								
CERTIFICATION	resulting in deeth) LAS	' (	d											
A L	PART II. Other algnifice	nt condition	e contributing to	deeth but	not resultin	g in the u	nderlying	g ceuse	given in	Pert i. 24	a. WAS AN		24b	WERE AUTOPSY FINDINGS
MEDIC	Clised he	ad yu	auma		and				afor	na .	PERFOR	3/		AVAILABLE PRIOR TO CDMPLETION DF CAUSE DF DEATH?
ME	requiring		/		nati									1 TYES 2 NO
AN	DID TOBACCO U		RIBUTE TO CA		PLACE OF DE			UNC	ERTAIN	4 D				
SICI	EXAMINER?		HOSPITAL:			QT/HE	R:	a 5 ∏ B	eldence	8 Other (S	nacifu)			
PHYSICIAN:	27. MANNER OF DEATH		26a. DATE OF (Month, D	INJURY	26b. T	IME OF	26c. INJ			28d. DESCR		NJURY OC	CURED	
BY	1 X Natural 5 1 1 2 Accident	Pending Investigation				М	1 🗆 1	/ES 2 [	NO					
		Could not be determined	26e. PLACE O building,	F INJURY atc. (Specify)	At home, tern	, atreet, fac	tory, office	•	1	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
	29a. CERTIFIER 1 CERT	IEVING BUVE	CIAN. To the best of			0.000								
COMPLETE			CIAN: To the best of R: On the besis of e											e) end manner as stated.
L C	29b. SIGNATURE AND TITLE								ENSE NUM					(Month, Day, Year)
TO BE	m-Jeabelle !	Tack	Jugar M	)				-	365			►a		30,1995
=	30. NAME AND ADDRESS OF	PERSON WH			(ITEM 27) (Ty		un V	100	. 12 11	1 1 mm h	200	7		
	31. OATE FILED (Month, Day,	YEARL -				0 00.	TUH	281	10 h	17707	VKE,	1 11 1	112	-11
	MAY OF 1	UOK	32, REGISTRA	Los-An	A-11									

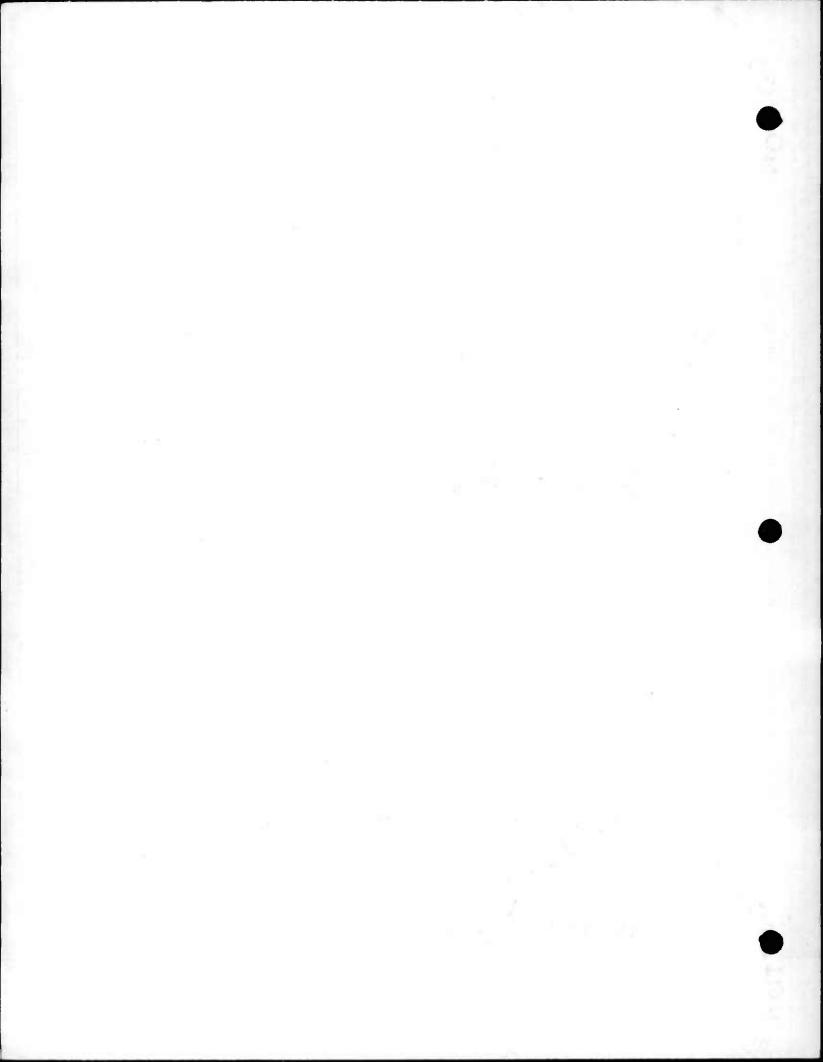
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO BE COMPLETED BY FUNERAL DIRECTOR BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION S AMSEL
31. DATE FILED (MONTH, Day, Your)
MAY 0 3 1995

						95	13350
FOR 1 . STATE	STATE OF MARYLA	ND / DEPAR	TMENT OF H	EALTH AND N	MENTAL HYGIEN	IE	
REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO		
1. DECEDENT'S VAME (First, Middle, Last)	B. Ca	pelar	nd		2. DATE OF DEATH	AY 1995	3. TIME OF OEATH
0:00 0 0 0 0 000	S. SEX 6. AGE (In	yrs. fest birthday)  Z YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	1912 8. BIR	THPLACE (State or Foreign intry)
3814 CCA-C	t and number) Rola le Ro	X	96. CITY, TOWN O	R LOCATION OF DE	ATH	9c. COUNTY OF	DEATH .
RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY	1.1	10c. CITY	r, TOWN OR LOCAT	ION			10d. INSIDE CITY
10s. STREET AND NUMBER	1 1 2		100	ZIP CODE		10g. CITIZEN OI	1 X YES 2 NO
3814 Cedara	2. WAS DECEDENT EVER IN L	C ADMED	1 40 100 050	21219	2	U.	SA
1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 TYES IF YES, GIVE WAR OR DATE	2 NO	If yes, spi	elfy Cuben, Maxican 2 NO Specify:		Bio	CE - American Indian, ack, Whita, atc. octly: Black
1 7 7 - 1 10.	mpleted) College (1-4 or 5+)	(Give kind of w life. Do NOT us	-	of working	16b. KIND OF BU	Hmire	city
17. FATHER'S NAME (First, Middle, Last)	naster 1	Educa	TOP	18. MOTHER'S NAM	IE (First, Middle, Majden	Sumamp)	andel Court
19a. INFORMANT'S NAME (Type/Print)	Dank		ADDRESS (Street a	Urst.	oute Number, City or Tow	anks	
Dr. Vesta O.	Griffin	804	Semi		Drive S	u Hol	K, V. 23434
26a. METHOD OF OISPOSITION  1 Deviate 2 Cremation 3 Removal  4 Donation 6 Other (Specify)	from State	LACEANODATEO	her pigge (mu	1 11.	5/2/95 P	trbutu	/
21. SIGNATURE OF FUNERAL SERVICE LICENS	. Dhomps	in Je	22. NAME AN	D ADDRESS OF FAC	H. west Ja bash	Ave.	
23. PART I. Enter the diseases, or com	plications that caused t	he death. Do n	ot entar the mod	le of dving, such		irstory arrest	Approximate
shock, or heart fallure. List iMMEDIATE CAUSE (Final disease or condition resulting in death)	t only one cause on eac	h iina.	cut	lan	line	A.	interval Between Onset and Death
	DUE TO (OR AS A C	ONSEQUENCE OF	):			,	14
Sequantially list conditions, if any, leading to immediata cause, Enter UNDERLYING	DUE TO (OR AS A C	ONSEQUENCE OF	):		_		
CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A C	ONSEQUENCE OF	):				
PART II. Other significant conditions c	antellection to death but	0	-0.0				
aulom	www.	here	Lytu	Cause given in P	Perf i. 24a. WAS AN PERFOR		Ib. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
			0		_	/	1 TYES 2 NO
DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEAT		UNCERTAIN			
	OSPITAL:	577 J = 1 30 T	OTHER:	5 Residence 6	Other (Specify)		
27. MANNER OF OEATH	28a. DATE OF INJUSTY (Month, Day, Year)	200. TIME	OF ISC. NUL	TA YIN	26d. DESCRIBE HOW I	NJURY OCCUREO	
2 Accident Investigation	28e. PLACE OF INJUNY	At thoma, turn, ut	M 1 Y	-	284 I OCATION (Charles		
4 Homicide determined	building, etc. (Specific	<i></i>	7		261. LOCATION (Street a City or Town, State)	uru ivurnoer of Hure.	r noute Number,
	N: To the best of my knowled on the beals of examination a						(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CENTIFICE	Mel			29c. LICENSE NUME	BER 7	29d. DATE SIGNE	2895
	OMPLETED ONUSE OF DEATH	1 (ITEM 27) (Type,	Print)	Ut. 21	101		4//
7 NWIZOL B	VI Java	- Uu	00 1 0	XI. LI	W.		

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OF VITAL RECORDS, P.O. BOX 68760,	IAN. The law requires that the death certificate he executed within 74 ho
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DESCORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPIN, CONTROLL OF A PARTICLAND PROPERTY. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNETAL URECURE AS this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARY		RTMENT OF		MEN	TAL HYGIENI REG. NO.	E		
	1. DECEOENT'S NAME (First, Middle, Last)	P clark				M	ATE OF DEATH DAY	1 9	S. TIME OF GEATH	
- 1	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	(A	ATE OF BIRTH Aonth, Day, Year)		BIRTHPLACE (State or Foleign Country)	
1	218-12-8840  9a. FACILITY NAME (If not institution, give s	1 X M 2 F	72 YRS.	SP CITY TOWN	OR LOCATION OF		t. 2, 1922		Maryland	
DIRECTOR	Northwest Hospit	340710 651			ndallsto			Baltimore		
3EC	10a. STATE 10b. COUNT	Y	10c, CI1	Y, TOWN OR LOCA	TION				10d. INSIDE CITY	
ā		oll County		S	ykesvill	Le			1 YES 2 X NO	
FUNERAL	10e. STREET AND NUMBER			10	f. ZIP CODE		,	10g. CITIZEN OF WHAT COUNTRY?		
J. N.	513 Piney Run	12. WAS DECEDENT EYER	IN U.S. ARMED	12 WAS DE		2178	IIGIN? (Specify Yas	U.S	• A •	
B₹	1 Never Merried 2 Married 3 Widowed 4 Divorced	FORCES? 1 XYES	If yes, a	ecify Cuban, Mexico	can, Pue	Or NO — 14	Black, White, etc.  Specify: White			
8	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	18a. DECEOENT'S	USUAL OCCUPATI work done during m se retired.)	ON ast of working		16b, KINO OF BUS	INESS/INDUS	TRY	
COMPLETED	Elementary/Secondary (0-12)	Elementary/Secondary (0-12) College (1-4 or 5+) Welde:  1.2 Welde:					Gover	nment	(IIS)	
OM	17. FATHER'S NAME (First, Middle, Lest)		Merc	IEL	18. MOTHER'S	NAME (F)	rst, Middle, Malden S		(03)	
BE C	James Ph	ilip Clark				lild		Jnknow	n	
10	19a. INFORMANT'S NAME (Type/Print)  Mrs. Joyce L. Cl	ark	196. MAILING 513	AODRESS (Street Piney R	and Number or Run	al Route I	Number City or Town	State, Zip Co	^{de)} 21784	
	20e. METHOD OF DISPOSITION  XIX Burlet 2	oval from Stata ce	b. PLACE AND OATE	OF DISPOSITION (Number place)	Park 5	15/9	DATE 20c. LOC	ration – city	or Town, State	
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE		22. NAME A	ND ADDRESS OF	FACILITY				
	▶ Drian &	( Daight	4				HOME (P. 21784 (4			
NOI.	23. PART I. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cardiec or respiratory arrast,  Approximate intervel Batween Onset and Death  Due to (or as a consequence of):  Sequentially list conditione, If any, leading to immediate									
CERTIFICATION	c. DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  C. DUE TO (OR AS A CONSEQUENCE OF):									
	PART II. Other eignificant condition	ns contributing to death	but not regulting	In the underlyin	n ceuse alven	n Part	. 24e. WAS AN A	HITOBEV	24b. WERE AUTOPSY FINDINGS	
EDICAL				- III			PERFORM	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?	
PHYSICIAN: MEDI	DID TOBACCO USE CONTI	RIBUTE TO CAUSE (	OF DEATH Y	S [] NO [	UNCERTA	IN			1 TYES 2 NO	
CIAI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	TH (Check only one)						
YSI	1 TYES 2 NO	1 Inpatient 2 - ER/Out			e 5 🗆 Rasidenc	6 🗆 0	Other (Specify)			
ВУ РН	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	URY W	URY AT PRK? YES 2 NO	28d.	OESCRIBE HOW IN	JURY OCCUR	ED	
	3 Suicide 6 Could not be 4 Homicide determined	28e, PLACE OF INJUR building, etc. (Spo	Y — At home, tarm, ecify)	street, factory, offic				. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
COMPLETED		CIAN: To the beat of my known in the beats of examination							suse(a) and manner as stated.	
88	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE N	UMBER	7(/	29d. DATE SI	GNED (Month, Day, Year)	
٥	30. NAME AND ADDRESS OF PERSON WH	O COMPLETEO CAUSE OF O	EATH (ITEM 27) (Type	1 = 1 2	A. 701	12.	7	4)		
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIG	NATURE	1705	e Ned	, 100	MONIT	wn	md	
	MAY 0 4 1995 34	ul divoler la	tell							

DHMH-16 Rev 1/89

REG. NO

BALTIMORE, MARYLAND 21215-0020

STATE REGISTRAR

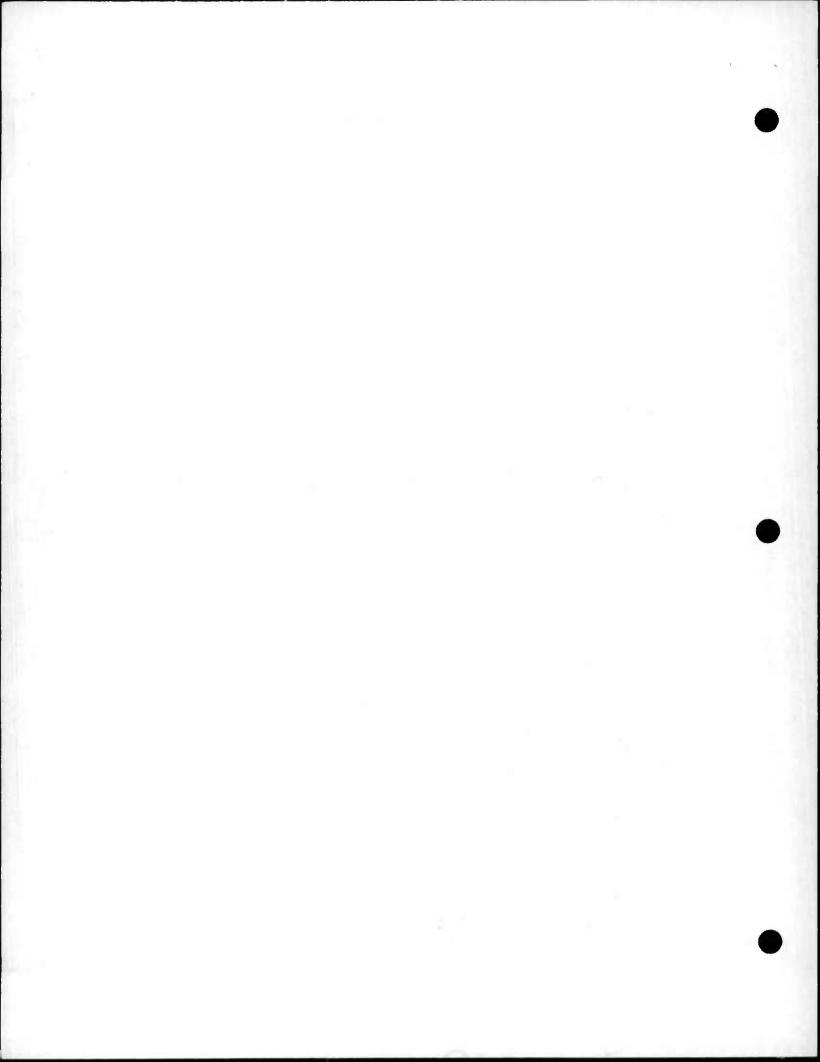
DIVISION OF VITAL RECORDS, P.O. BOX 68760

1. DECEDENT'S NAME (First, MA 2. DATE OF DEATH TIME OF DEATH SOT 210A. 309 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 1 M 2 F HOURS 244-36-6327 YRS June North Carolina permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Carroll County General Hospital Westminster Carroll RESIDENCE OF DECEDENT 10b. COUNTY 10c CITY TOWN OR LOCATION 10d. INSIDE CITY Carroll Maryland Westminster 1 YES 2 K NO 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 419 London Court been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit, of Health and Mental Hygiene prior to burial, cremation, or removal. 21157 United States hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puarto Rican, atc.)

1 YES 2 NO Specify: 14. RACE — American Indien, Black, White, etc. FORCES? 1 YES 2 NO 1 Never Married 2 Married B Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) 10th grade Clerk C.V.S. Pharmacy 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) 75 Elmer Epley Katie Case BE notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Denise Kay Mundy 419 London Ct. Westminster, MD pe 20a. METHOD OF DISPOSITION 20b. PLACEAND DATE OF DISPOSITION (Name of 29c. LOCATION -- City or Town, Stata must DATE ty Burlat 2 Cremation 3 Re 4 Donation 5 Other (Specify) Lake View Mem. Park 5/2 Sykesville, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Rd. Winfield, MD 21784 the medical 23. PARTY Epter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate lock, or heart failure. List only one cause on Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) mas requires that the death certificate be executed within event. DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury other DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST 10 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY U shows any 1 TYES 2 OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES X NO UNCERTAIN OR ATTENDING PHYSICIAN: The law has by Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate to the State HOSPITAL: OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 6 27. MANNER OF BEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF with 1 28d. DESCRIBE HOW INJURY OCCURED marked, Natural Accident 5 Pending м After the 1 YES 2 NO BY 28a. PLACE OF INJURY — At home, farm, streat, factory, office building, etc. (Specify) 3 Suicide DIRECTOR: A hours after d .00 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 28 4 Homicide detarmined Item CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the ilme, date and place, and due to the cause(s) and menner as stated. (Check only one) HOSPITAL FUNERAL within 72 h = TO THE HOSPITA
TO THE FUNERAL
DE filed within 72
IMPORTANT: If 2 MEDICAL EXAMINER: On the bests of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE ADD TITLE OF CERTIFIER 29c. LICENSE NUMBER BE MO 29d. DATE SIGNED (Month, Day, Year) IND ADDRESS OF PERSON WHO COMPLETED CAUSS OF DEATH (ITEM 27) (Type, Print) 2 32 AREGISTRAR'S OF

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

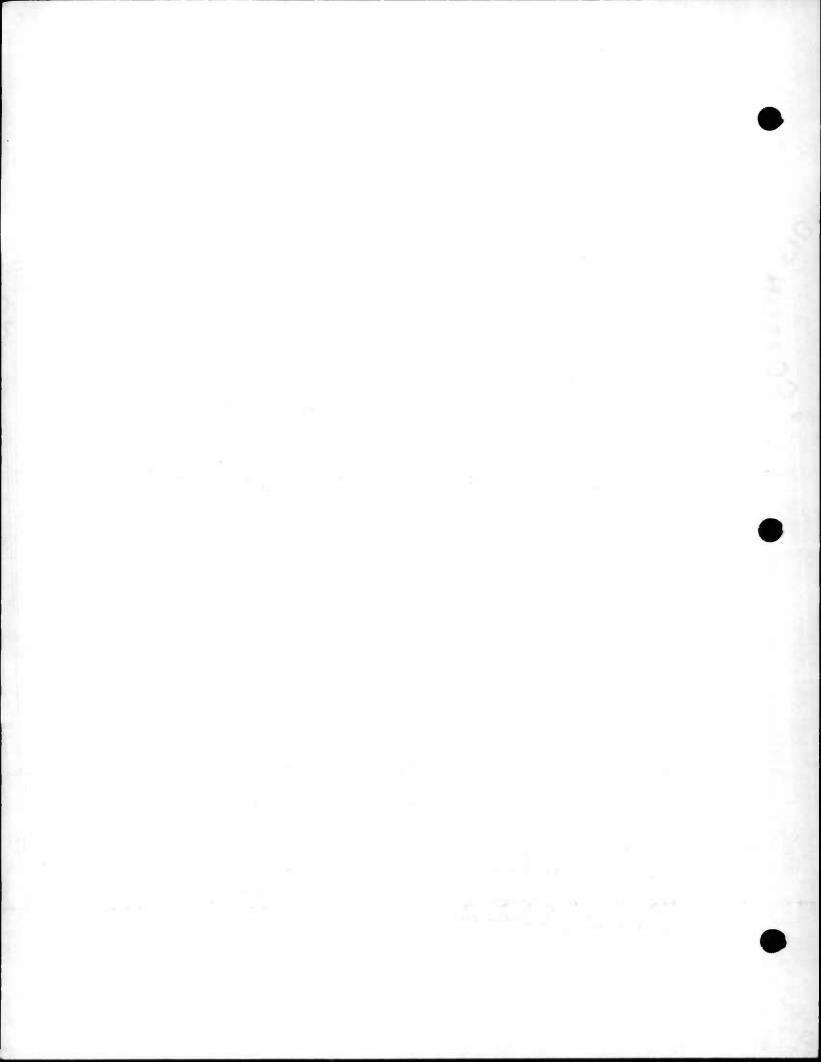
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. **BALTIMORE, MARYLAND 21215-0020** DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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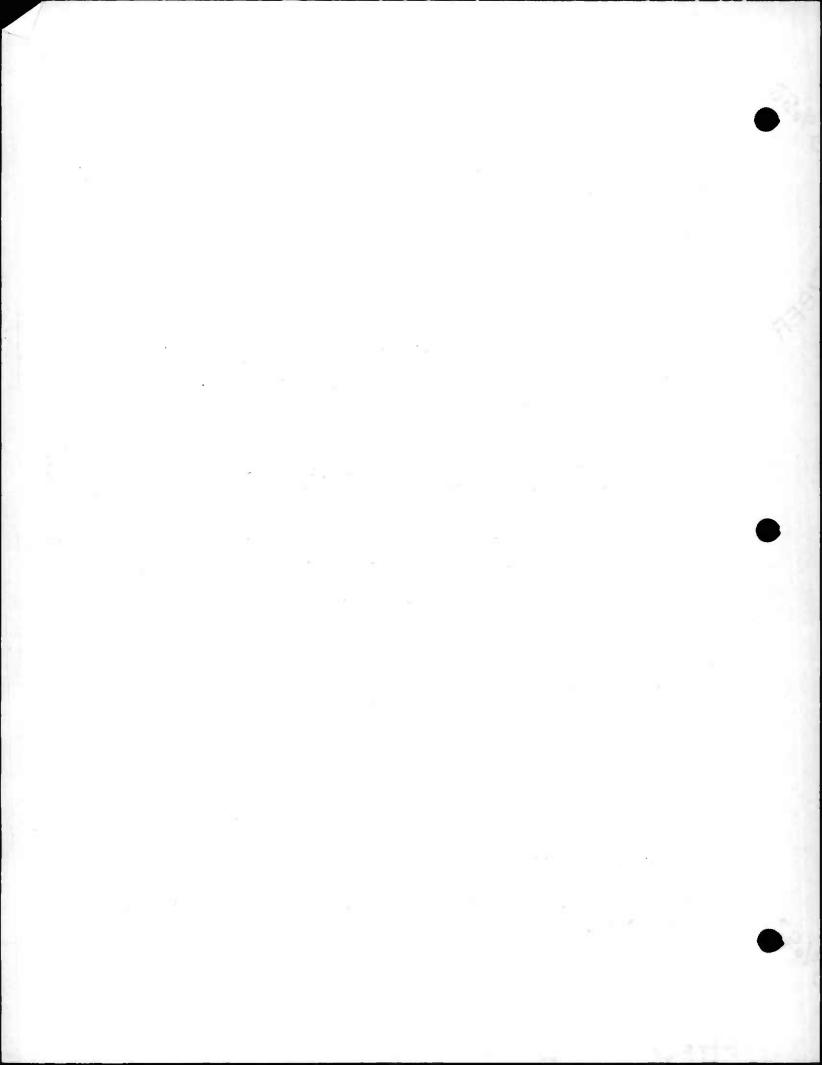
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	1. DECEDENT'S NAME (First, Middle, Last) SUSANNE	IF	ONA		D	UVA	T T	2.1	DATE OF DEATH DATE OF DEATH DATE	3. TIME OF DEATH 11:00P M		
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. las	a himbala a		_				199		11:00P M
	216-76-2466	1 - M 2 1/2 F	3.8	YRS.	MONTHS DA	-	UNDER 24 HE		Month, Day, Year) WICH 15,	1957		PLACE (State or Foreign Waryland
		9e. FACILITY NAME (If not institution, give street and number)				b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEA						
5	DOGWOOD AND LI	DOGWOOD AND LITTLECREEK DR			WOO						LTIM	
DIRECTOR	RESIDENCE OF DECEDENT									DA	DITI	OKE
E	10a, STATE 10b, COUNTY			10c. CITY	, TOWN OR L							10d, INSIDE CITY LIMITS?
		ltimore			Balt	imor	e					1 YES 2XXNO
FUNERAL	10e. STREET AND NUMBER					10f. ZIP				10g. CIT		HAT COUNTRY?
<u>H</u>	8542 Dogwood R						2120				us	SA
J.	11. MARITAL STATUS  1 📈 Never Married 2 🗌 Married	12. WAS DECEDENT . FORCES? 1	YES 2XX	MED 10	It ye	s, specify	Cuben, Me	axican, Pu	RIGIN? (Specify Yes	or No-	14. RACE Black	— American Indian, White, etc.
ВУ	3 Widowed 4 Divorced											Vhite
ED	15. DECEDENT'S EDUC	CATION	18e, DE	CEDENT'S	USUAL OCCU	PATION			16b. KIND OF BUS	INESS/IN		ville
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4 or 5+)	(Gi	Do NOT us	ork done durin e retired.)	g most of	working					
4	12		F	ood S	Servic	e			Deli	cate	ssen	
Į	17, FATHER'S NAME (First, Middle, Last)					18.	MOTHER'S	NAME (F	irst, Middle, Maiden	Sumame)		
BE	Carlisle W. Du	vall					Annie	e Ma	y Humple			
TO .	19a, INFORMANT'S NAME (Type/Print)								Number, City or Town			
F	Annie May Duvall		8	542 T	Dogwood	d Ro	ad	Bal	timore,	Md.	2120	7
	20a. METHOD OF DISPOSITION 1 [XBurlel 2 ] Cremation 3 ] Remo	oval from State	20b. PLACE A	NDDATEO	FOISPOSITIO	N (Name o	/		DATE 200 LO	CATION	City or Tou	vn, Stata
4 Donation 5 Other (Specify) Mt. Paran Cemetery 5-5-95 Rand								dallstown, Md.				
	21. SIGNATURE OF FUNERAL SERVICE LIC		22, NAM	E ANO A	OORESS OF	F FACILITY				wn Road		
	E. Brien	Poural			Eli.	ne. F	шполо	al. H	ome Rei			
-	23. PART I. Enter the disease, or c shock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	UR CE	3							Approximate Interval Batween Onset and Death		
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):											
	PART II. Other algnificant conditions	contributing to de	eath but not re	sulting in	the under	ying ce	use given	In Part	i. 24e. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
MEDICAL									1 YES 2			AVAILABLE PRIOR TO COMPLETION OF CAUSE
									1 W YES 2	□ NO		DF DEATH?
	DID TOBACCO USE CONTR	IBUTE TO CAU	SE OF DEAT	TH YES	S $\square$ NO	П	JNCERT	AIN C	1			T TES 2 NO
₹ I	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				1 (Check only				-			
S	1 NES 2 NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ E	R/Outpetlant 3		OTHER:	Home 5	☐ Residen	co 6 🗆 X	other (Specify) R	OADV	VAV	
PHYSICIAN:	27. MANNER OF DEATH	26a. DATE OF IN (Month, Day,		28b, TIME	OF 28c	INJURY WORK?		_	DESCRIBE HOW IN		-	vahas
BY	1 Natural 5 Pending 2 Accident Investigation	5 1	45	2122		YES	2 NO	Do	IVER OF	was:	smu	CIL BY ALOTHER
	3 Suicide 6 Could not be	26e. PLACE OF I	NJURY - At hor	ne, farm, at	reet, tectory,	office		261.	LOCATION (Street a City or Town, State)			
	4 Homicide determined	7				h	WOODELIT	Théch	SEL DE	2. BALTIMORE TO		
29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.												
§	one) 2 MEDICAL EXAMINER											end manner ee stated,
w I	29b. SIGNATURE AND TITLE OF CERTIFIER	. 1/				290	LICENSE I	NUMBER	T	29d. DAT	E SIGNED (	Month, Day, Year)
m	Marylite One	your					O.C.	.M.E				2 1995
۹ ا	30. NAME AND ADDRESS OF PERSON WHO											
	MAINDONNO D			enn	Stree	et,	Balt	timo	ore, Ma	ryla	and :	21201.
1	31. DATE FILEO (Mogth Per Yer)	J'ADOLOGIA	SHOW AFTER									



BALTIMORE, MARYLAND 21215-0020	nours after death. Page 6 may be retained by the hospital or attending physician
,092	d within
ITAL RECORDS, P.O. BOX 68760	execute
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DIVISION OF VITA	ENDING
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FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HY
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1 7	REGISTRAR  1. DECEDENT'S NAME (First, Middle, Las	et)	CERTIFI	CATE OF	DEATH	REG. NO		3. TIME OF DEATH				
		ohan , Jr.				MONTH D		EAR				
1 1	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	199	BIRTHPLACE (State or Foreig				
	215-05-4023	Δ	78 vrs.	MONTHS DAYS	HOURS MIN.	July 26,1		Country) Md				
-	9e. FACILITY NAME (If not institution, give			96. CITY, TOWN	OR LOCATION OF D		9c. COUNTY	OF DEATH				
ЕСТОВ	St. Agnes Hospin	tal		Balti	lmore		n	JA				
EC	10e. STATE 10b. COUN	NTY	10c. CITY	, TOWN OR LOCA	ATION			10d. INSIDE CITY				
DIR	Md 🦳	n I A	В	altimor	:e			1 TY YES 2 NO				
1 K	10e. STREET AND NUMBER	2 1		10	M. ZIP CODE		10g. CITIZEI	N OF WHAT COUNTRY?				
UNERAL	330 Westshire				21229			USA				
14	11. MARITAL STATUS  1 Never Merried 2 Merried	12. WAS DECEDENT EVER IN FORCES? 1 X YES	2 NO	If yes, s	pecify Cuban, Maxic	NIC ORIGIN? (Specify Yearn, Puarto Rican, etc.)	8 or No- 14	. RACE — American Indian, Black, White, etc.				
BY	3 Widowed 4 Divorced	WW II	ATES	1 NE	S 2 XNO Speci	<b>/y</b> :		Specify: white				
윤	15. DECEDENT'S Et (Specify only highest gra	DUCATION ade completed)	18e. DECEDENT'S I	USUAL OCCUPATI ork done during m	ION post of working	16b. KIND OF BU	SINESS/INDUS					
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	e retired.)	out of working							
COMPLET	12		Sales M	lanager			MFG					
	17. FATHER'S NAME (First, Middle, Last)  Ernest L. Drohar	n			Sumame)							
BE	19e. INFORMANT'S NAME (Type/Print)	1.0		ret Miller								
TO B	196. INFORMANT'S NAME (Type/Print)  196. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code)  330 Westshire Road, Balto, Md. 21229											
	20a. METHOD OF DISPOSITION  1 Burlet 2 Commatten 3 Removal from State  20b. PLACE AND DATE OF DISPOSITION (Name of general core)  20c. LOCATION — City or Town, State general core in the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the part of the											
	4 Donation 5 Other (Specify)	Cr	netery, crematory or oth nesapeake	Cremat	ory	5/4 Be1	tsvill	e, Md 20705				
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE			ND ADDRESS OF F	CILITY						
	Kuter D.	dalita mo	11000			on Funeral Avenue, B		Md. 21228				
	23. PART J. Enter the diseasea, o	r complications that cause	d the death. Do no	ot enter tha me	oda of dying, aud	ch as cardiac or resp	Iratory erres	, Approximate				
	IMMEDIATE CAUSE (Final	e. Liet pnly one ceuse on e	ach iina.					Interval Bet Onset and I				
	disease or condition resulting in death)	a. Diffuse al	veolar da	amage (A	ARDS), lu	ings		1 week				
			CONSEQUENCE OF		1	- 1.		4.0				
RTIFICATION	Sequentially list conditions,  Due To (OR AS A CONSEQUENCE OF):  Sequentially list conditions,  Due To (OR AS A CONSEQUENCE OF):											
CATION	if any, leading to immediate cause. Enter UNDERLYING	_α Metastatic										
RTIFIC	CAUSE (Disease or injury thet initiated eventa	DUE TO (OR AS A	CONSEQUENCE OF	):	Inoma,	ung		8 mos.				
	reaulting in deeth) LAST	d										
C	PART II. Other significant condition	Dns contributing to deeth b	out not reculting in	n the underlyin	ng ceuse given in	Part J. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FIND				
<u>8</u>		PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAL								
: MEDIC	Unknown tobacco use											
2 3	DID TOBACCO USE	CONTRIBUTE TO	CAUSE OF	DEATH Y	YES NO			1 XYES 2 NO				
YSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				PLACE OF DEATH (C)	neck only one)						
YSI	1 TES 2 T NO	HOSPITAL: 1 Xinpetiant 2 ER/Outs		OTHER: 4   Nursing Hor	me 5 - Residenca	6 Other (Specify)						
ву Рн	27. MANNER OF DEATH  1 X Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU		JURY AT ORK?	28d. DESCRIBE HOW	NJURY OCCUP	RED				
B	2 Accident Investigation				YES 2 NO							
	3 Suicide 8 Could not b 4 Homicide determined		7 — At homa, farm, st cify)	treet, factory, offi	ce	281. LOCATION (Street City or Town, State)	end Number or	Rural Route Number,				
	4   Homicide determined											
TED	29e. CERTIFIER (Check only coel) 1 Terrifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated.											
APLETED	(Check only		one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end placa, and dua to the cause(a) and manner as stated.									
COMPLETED	(Check only one) 2 MEDICAL EXAMI	INER: On the basis of examination	in end/or investigation	U-47/11/2400	29c. LICENSE NUMBER 29d. DATE SIGNED							
APLETED	(Check only	INER: On the basis of examination	On }			MBER		IGNED (Month, Day, Year)				
E COMPLETED	(Check only 1 CERTIFYING PHY ONE) 2 MEDICAL EXAMI	INER: On the basis of examination	on }	> ,	29c. LICENSE NU DO4964	MBER						
BE COMPLETED	(Check only one) 2 MEDICAL EXAMI	INER: On the basis of examination	ATH (ITEM 27) (Type,	> ,	D04964		► Ma	y 3, 1995				



DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 m	EUNERAL DIRECTOR After the certificate has been signed by the attending obvision and completely filled in by the funeral director

_	1 - STATE REGISTRAR	STATE OF MARY			OF DEAT		REG. NO.	Ė			
	1. DECEDENT'S NAME (First, Middle, Lest)	H. DIL				M	ATE OF DEATH DA		YEAR 72.50 P		
	4. SOCIAL SECURITY NUMBER 218-07-7161	1 <del>∏</del> M 2 □ F	(In yrs. lest birthday)		DAYS HOURS	MIN. Se	ATE OF BIRTH Month, Day, Year) ept 12, 1	918	8. BIRTHPLACE (State or Foreign Country) MD		
OB	9a. FACILITY NAME (If not institution, give s St. Agnes Hospita				own on Locatio			9c. COUN	N/A		
DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY  Md  N/A		10c. CI	ry, town on Balti			10d. INSIDE				
	100. STREET AND NUMBER 300 Capitol Cour			Dalti	101. ZIP CODE 2122	1		10g. CITIZ	1 € YES 2 NO		
BY FUNERAL	11. MARITAL STATUS  1 Never Married 2 Married  3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 🖾 YES IF YES, GIVE WAR OR I	2 NO	lf y		HISPANIC OR Maxican, Pue	RIGIN? (Specify Yes erto Rican, etc.)	or No-	USA  14. RACE — American Indian, Black, White, etc.  Specify: White		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	ON 18s. DECEDENT'S USUAL OCCUPATION (Give kind of work one during most of working life ID. NOT use wind of working						USTRY		
1 111	17. FATHER'S NAME (First, Middle, Last) John H. Diller		Sal	es		ers name (Fi	irst, Middle, Maiden S		rship		
TO B	19a. INFORMANT'S NAME (Type/Print) Catherine Healy				Street and Number of	r Rural Route I	rel Route Number, City or Town, State, Zip Code) , Eldersburg, Md. 21784				
ID OT	20b. PLACE AND DATE OF DISPOSITION   DATE   20c. LOCATION — City or Town, State   4   Donation 5   Other (Specify)   Chesapeake Crematory or other place)   5/2   Beltsville, Md   21. SIGNATURE OF FUNERAL SERVICE LICENSES   Sterling Ashton Funeral Home   736 Edmondson Avenue, Balto, Md. 21228										
CERTIFICATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE C	F):	7 fo	Iu	$\mathcal{L}$		Dey Dey		
MEDICAL	PART II. Other significent condition  DID TOBACCO USE CONTI	Der	menti	P		ven in Pert i	PERFORM	MED?	24b. WERE AUTOPSY FINDS AMAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMPLER?  1 7 YES 2 NO	HOSPITAL:	26. PLACE OF DEA	TH (Check only	( one)						
ву РНУ	27. MANNEP OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIR	IE OF 26	ic. INJURY AT WORK?	28d.	DESCRIBE HOW IN	JURY OCC	URED		
ETED	3 Suicide 8 Could not be determined	28a. PLACE OF INJUR building, atc. (Spe	Y — At home, farm, lotfy)	street, factory	, office	28f. (	LOCATION (Street ar City or Town, State)	pet and Number or Rural Route Number, ate)			
COMPL		CIAN: To the best of my known: R: On the bests of examination							d. cause(s) and manner as states		
TO BE C	290. SIGNATURE AND TITLE OF CERTIFIEF	Luo.			29c. LICEN	SE NUMBER	42	29d. DATE ▶ A+	SIGNED (Month, Day, Year)		
	30. NAME AND ADDRESS OF PERSON WHO  D. TURAKHIA  31. DATE FILED (MONTH) 1995  MAY	COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type T, Freal	Print)	Rd.	Bell:	nee	m	0 2/228		

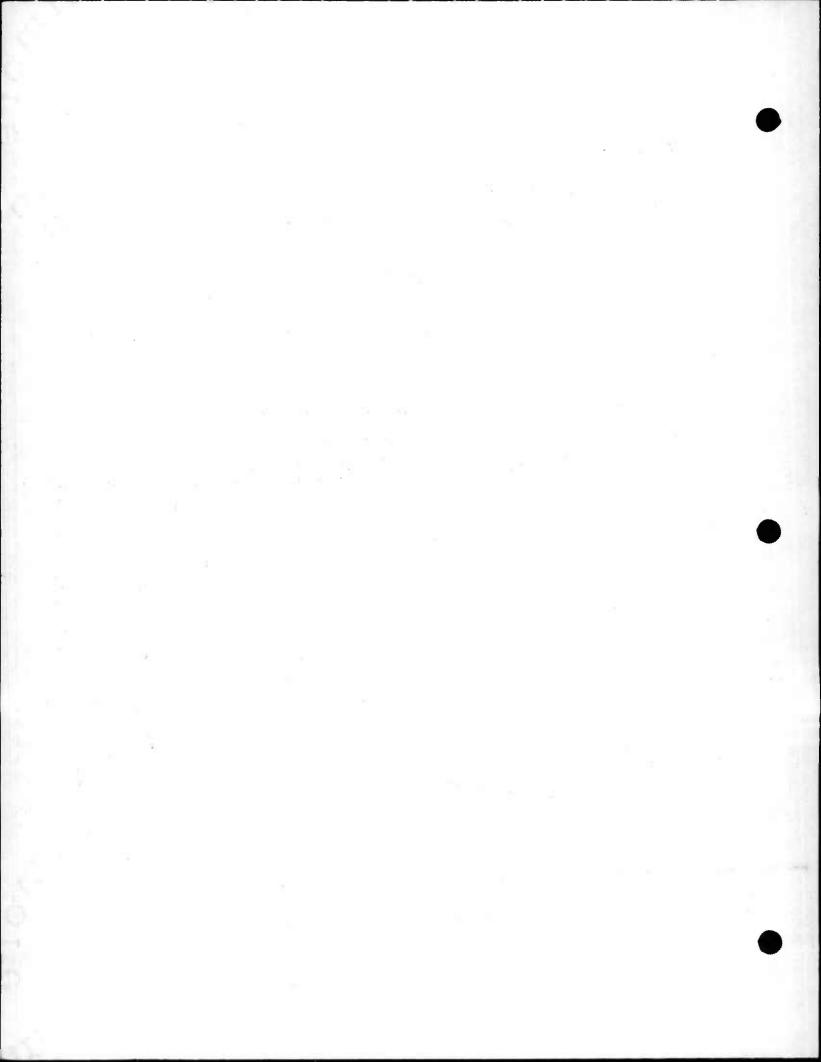
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLAND		MENT OF HEALTH AND	MENTAL HYG					
	1. DECEDENT'S NAME (First, Middle, Last) ZELDA		DUI	BIN	2. DATE OF DEATMONTH MAY 2,	пн	year 9:50AM M			
	4. SOCIAL SECURITY NUMBER 214–12–1964	5. SEX 1 M 2 X F 6. AGE (In yrs. In:		F UNDER 1 YEAR IF UNDER 24 HRS ONTHS DAYS HOURS MIN.	. 7. DATE OF BIRTI (Month, Day, Ye	d ar)				
Œ	9a. FACILITY NAME (If not institution, give a	reet and number)	9	b. CITY, TOWN OR LOCATION OF		7 10 10 10 10	9c. COUNTY OF DEATH			
СТО	7386 PARK HETGHTS			BALTIMORE		N/A				
DIRECTOR	MARYLAND 10b. COUNTY	N/A	10c. CITY, 1	OWN OR LOCATION BALTIMORE	1	10d. INSIDE CI LIMITS? 1 √ YES 2 [				
FUNERAL	100. STREET AND NUMBER 7386 PARK HEIGHTS	AVE.		10f. ZIP CODE 2120	8	10g. CITIZEN OF WHAT COU USA				
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. WAS DECEOENT EVER IN U.S. AF FORCES? 1 YES 2 IF YES, OIVE WAR OR DATES	MED	13. WAS OECENDENT OF HIST If yes, specify Cuban, Max 1 — YES 2 — NO Spe	y Yea or No— 1	14. RACE — American Indian, Black, White, etc. Specify: WHITE				
COMPLETED	15. DECEOENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	ECEDENT'S US live kind of work b. Do NOT use n	VIAL OCCUPATION k done during most of working etired.) SALESPERSON	F BUSINESS/INDU	JSTRY					
BE COM	17. FATHER'S NAME (First, Middle, Last) JACOB	YOSPY			NAME (First, Middle, Mi	alden Surname)	VIN			
10	19a. INFORMANT'S NAME (Type/Print) DR. ALAN DUBIN	19		DDRESS (Street and Number or Run			Code)			
	20e. METHOD OF DISPOSITION  **XSeurisi 2   Gremation 3   Removal from State  20b. PLACE AND DATE OF DISPOSITION (Name of compliant compliant output place).  20c. LOCATION — City or Town, State									
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE Itelluon	INGTON-	SOL LEVINSON	& BROS.,	INC.	MORE, MD 21215			
	Approximate shock, or heart fellure. List only one cause on each line.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in daeth) LAST  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):									
CAL	PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED?  1 YES 2 NO									
N. P	DID TOBACCO USE CONTE			NO UNCERTA	IN 🗆		1 - YES 2 NO			
SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLAC HOSPITAL: 1   Inpetiant 2   ER/Outpetiant 3	0	Check only one) THER:						
PHYSICIAN: MEDI	27. MANNER OF BEATH  1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	F 28c, INJURY AT	8 Other (Specify) 28d. DE\$CRIBE H	OW INJURY OCCU	JREO			
TED BY	2 Accident Investigation 3 Suicide 8 Could not be detarmined	28a. PLACE OF INJURY — At ho building, atc. (Specify)	me, farm, stre		281. LOCATION (St City or Town, S	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
COMPLETED		CIAN: To the best of my knowledge, da R: On the bests of axamination and/or								
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	a- Line		29c. LICENSE N	UMBER 873	29d. OATE 5	SIGNEO (Month, Day, Year)			
	Marchy A. Levine	COMPLETED CAUSE OF DEATH (ITER	M 27) (Type Pri	Suite 306	Battino	re, MI	2/288			
	31. MAYEO (1014 1995 Ju	A SUMBULION PAINTAINE								



Pages 1, 2, 3 should

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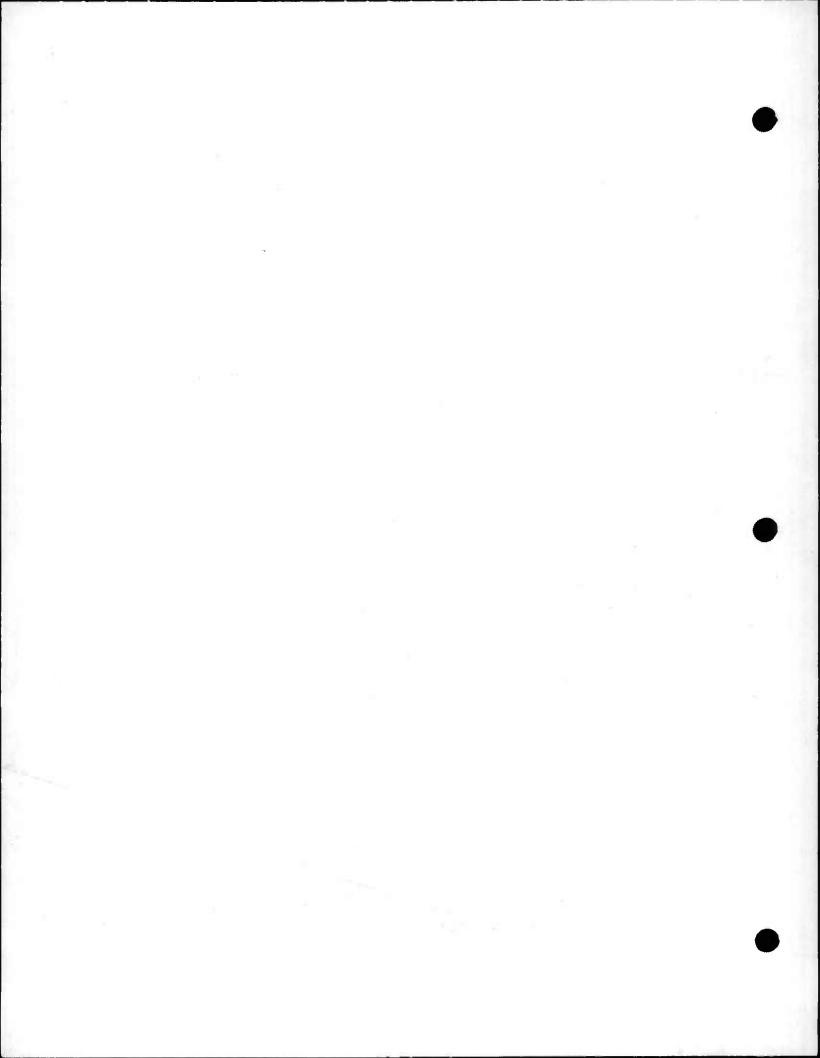
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OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicial	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-t		
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ROBERT Ρ. **EPPLE** MAY 1995 08:25 PM 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign AUG OI, 1916 159-16-0703 X M 2 □ F 78 Ohio 9a. FACILITY NAME (If not institution, give street and number) 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR THE JOHNS HOPKINS HOSPITAL N/A BALTIMORE CITY RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Montgomery Maryland Rockville 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 608 Crocus Drive 20850 USA 12. WAS DECEOENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexicen, Puerto Rican, etc.)

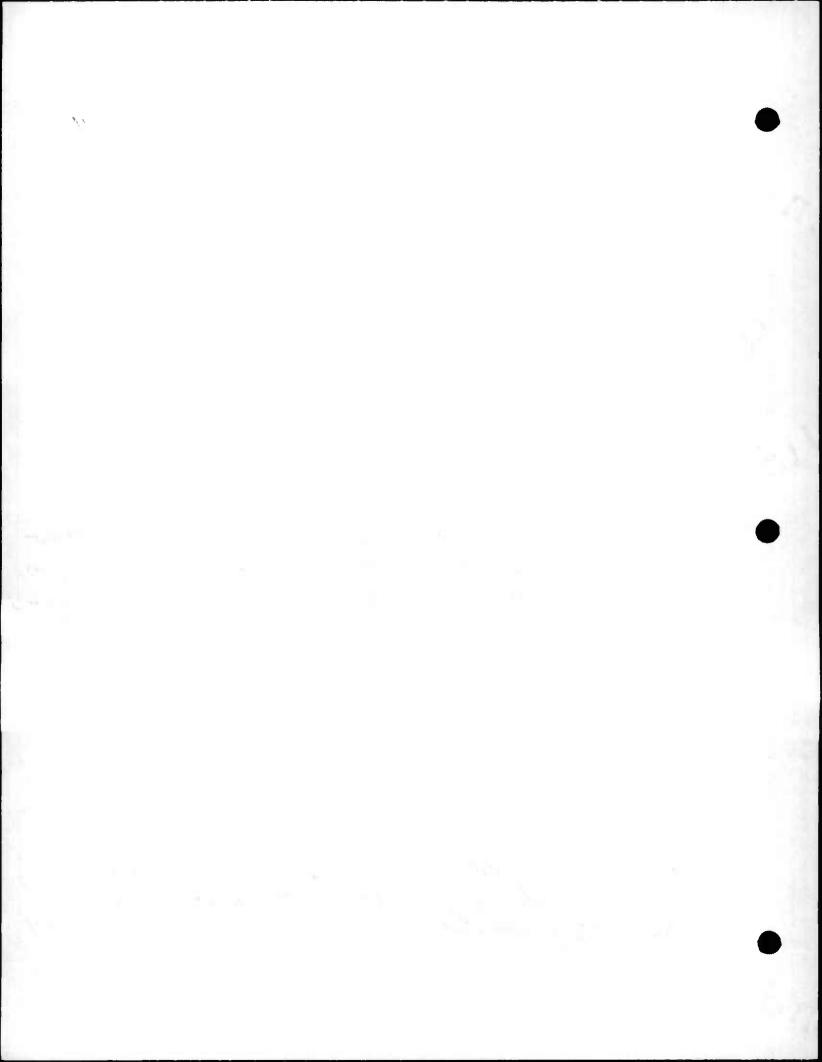
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY Specify. White 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Government Official U.S. Dept. of Energy 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Matthias Epple Laura Settel BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Marjorie E. Epple 608 Crocus Drive Rockville, MD 20850 9 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE must 1 Burial 2 X Cremation 3 Re 4 Donation 6 Other (Specify) Metro Crematory, Inc. 05/03/95 Baltimore, MD 21. SIGNATURE OF BUNERAL SERVICE ACENSES
George E. MacNabb examiner Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 medicai 23. PART i. Enter the diseases, or complicatione that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. Liet only one ceuse on each line. interval Betwe **IMMEDIATE CAUSE (Finei Onset and Death** the disease or condition_ Depsis event, resulting in death) Iwk DUE TO (OR AS A CONSEQUENCE OF) weymonia 2 wks traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING . Subdural hematama 1 month CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 6 injury, PART II. Other aignificent conditions contributing to deeth but not recuiting in the underlying ceues given in Pert i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL any Severe Dementic 1 YES 2 NO OF DEATH? Shows Diubetes Necilitus 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: S 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: tem OTHER: 1 TYES 2 NO K Inpatient 2 - ER/Outpatient 3 - DOA ng Home 5 - Residence 6 - Other (Specify) 9 27. MANNER OF DEATH 26s. DATE OF INJURY 26b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED marked, Netural Accident 5 Pending investigation 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 69 6 Could not be COMPLETED 4 Homicide Hem 29a, CERTIFIER 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the fime, date and place, and due to the cause(a) and menner as stated. TO THE HOSPITAL OF THE FUNERAL DE FINE WITHIN 72 NO IMPORTANT: If IN 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the films, data and place, and due to the cause(s) and menner as stated. 296 SIGNATORE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE MD-PhD JHH L8815 2 AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Julins Hopkins Hespital Depl Neurlog MD-PhD 32 REGISTRAR'S SI



	1. DECEDENT'S NAME (First,	ע בים אורינטו	CERTIFICATE OF DEATH						REG. NO.  2. Date of Death May 1, 1995  YEAR  3. TIME OF DEATH A				
				FRANCHETTI							995		// I
	4. SOCIAL SECURITY NUMBER 218 03 1091		5. SEX 6. AGE (In yrs.			MONTH	DAYS	IF UNDER 24 HRS. HOURS MIN.		th, Day, Year)		Country)	
	9a. FACILITY NAME (If not ins					9b. CITY, TOWN OR LOCATION OF DI					Italy INTY OF DEATH		
OH	7410 Alvah	Avenu					Dundalk					altimore	
2	RESIDENCE OF DEC	EDENT 10b. COUNT				CITY TOWN	TY, TOWN OR LOCATION						
DIRECTOR	Md.	imore			Dundalk							10d. INSIDE CITY LIMITS? 1 MYES 2 1 1	
AL	10e. STREET AND NUMBER					101. ZIP COOE			10g. C		CITIZEN OF WHAT COUNTRY?		
FUNERAL	7410 Alvah A	Avenue					21222					USA	
	11. MARITAL STATUS 1 Never Married 2 1	12. WAS DECEDED FORCES?	12. WAS DECEDENT EVER IN U.S. ARMI FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES		D 13. WAS DECENDENT OF HISPAI If yes, specify Cuban, Maxica 1  YES 2 NO Specif			ANIC ORIGI	an, Puerto Ricen, etc.)		t4. RACE — American India Black, White, atc. Specify: White		
BY	3 Widowed 4 Divon	W.W. 2		DATES				elfy:					
8	15. DECE (Specify only	CATION	TION 16		16a. DECEDENT'S USUAL OCC (Give kind of work done du		OCCUPATION during most of working		16b. KIND OF BUSINE				
YE.	Elementary/Secondary (0-	College (1-4 or 5	+)	life. Do No	avy Equipment Operato				Construct				
COMPLETED	5 17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)							<u> </u>	
BE C	Hugo Franchettoi						Maria De Giorgis						
TO B	19a. INFORMANT'S NAME (Type/Print)				19b. MAII	ING ADDRE	ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
F							Aldworth Road Dundalk, Md. 21222						
	20a. METHOD OF DISPOSITION  Surial 2 Cremation	3 🗆 Rem	oval from State	20th cen	b. PLACE AND DA	or other place	9)		O.E. DA1	110	CATION — C		510
	4 Donation 5 Other (		Gardens o				22. NAME AND ADDRESS OF FACILITY Charles S. Zeiler & Son Inc.						
	► 10 l.		n zul	) Bule									
	23. PART I. Enter the diseases, pr complications that caused the deeth. Do not anter tha mode of dying, such as cardiec or respiratory arrest,  Approximately the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the deeth of the												
	shock, or he IMMEDIATE CAUSE (Fine	art randre.	List only one car	use DN e	ech line.	D not and	n uia mo	da Di dying, ad	en aa ear	diec or respi	ratory arre	at,	Approxima
	disease or condition	Fuil	Failure							Onset and			
	resulting in death)  a. CUTACT TARGET TO THE TO (OR AS A CONSEQUENCE OF):											18 m 3 ye	
NO	Sequentially list conditions,  Due to for as a consequence of:											3 ye	
F	cause. Enter UNDERLYING												10
RTIFICATION	CAUSE (Disease or Injur that initiated eventa	E OF):	20				-	1090					
CERT	resulting in death) LAST												•
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										PERFORMED?		AWAILABLE PRIOR 1 COMPLETION OF CO OF DEATH?	
MEDIC													
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN												
20	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:												
PHYSIC	1 ☐ YES 2 NO 1 ☐ Inpatient 2 ☐ ER/Outpetient 27. MANNER OF DEATH 28s. DATE OF INJURY					3 DOA 4 Nursing Home 5 Residence 28b. TIME OF 28c. INJURY AT				8 Other (Specify)  28d. DESCRIBE HOW INJURY OCCURED			
ВУ Р	1 Natural 5 P	(Month, E	(Month, Day, Year) INJUI			M 1 YES 2 NO			Joseph John Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie				
0	3 Suicide 8 C	ould not be	28a. PLACE C	28a. PLACE OF INJURY — At home, farm, atreet, factory, obuilding, etc. (Specify)			ctory, offic	offica 2		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
ETE		etermined		Say Sa Toni, Salay									
릴	29a. CERTIFIER (Check only one)  CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.												
COMPL	2 MEDICAL EXAMINER: On the beats of axamination and/or investigation, in my opinion, death occured at i								e time, data and place, and due to the cause(a) and manner se sta				
BE	296. SIGNATURE AND TITLE	OF CERTIFIE	R /	- Our				29c. LICENSE NU				ATE SIGNED (Month, Day, Year)	
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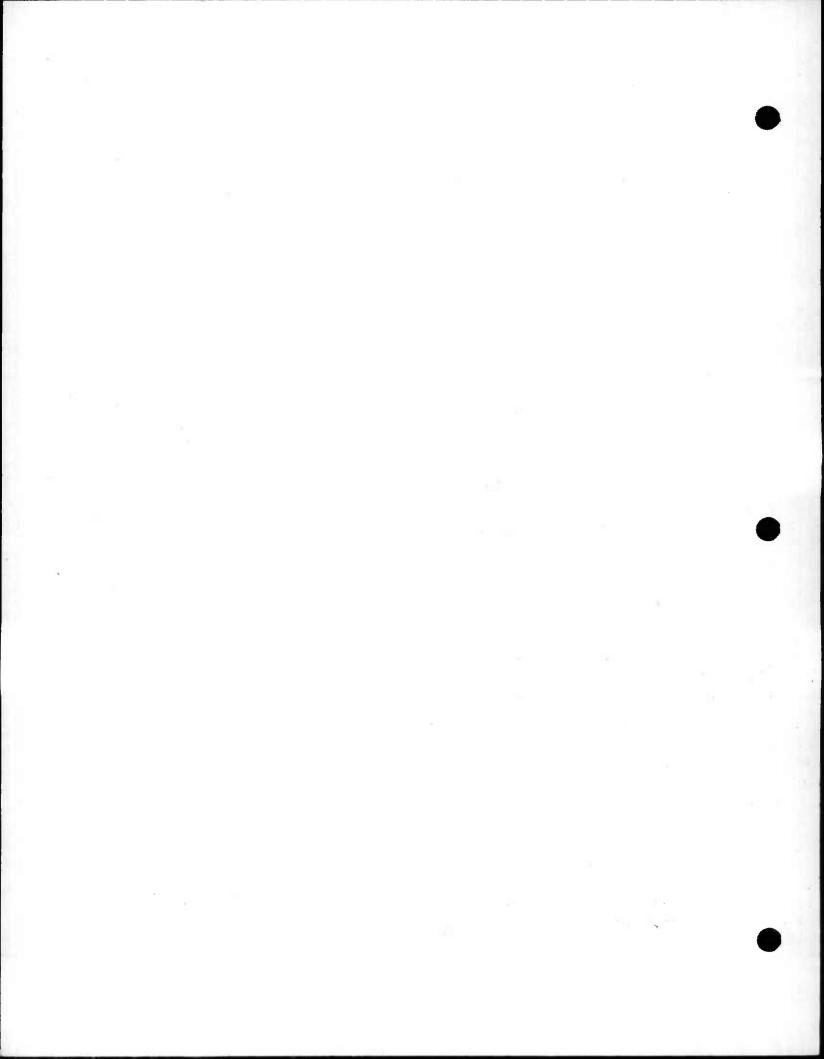


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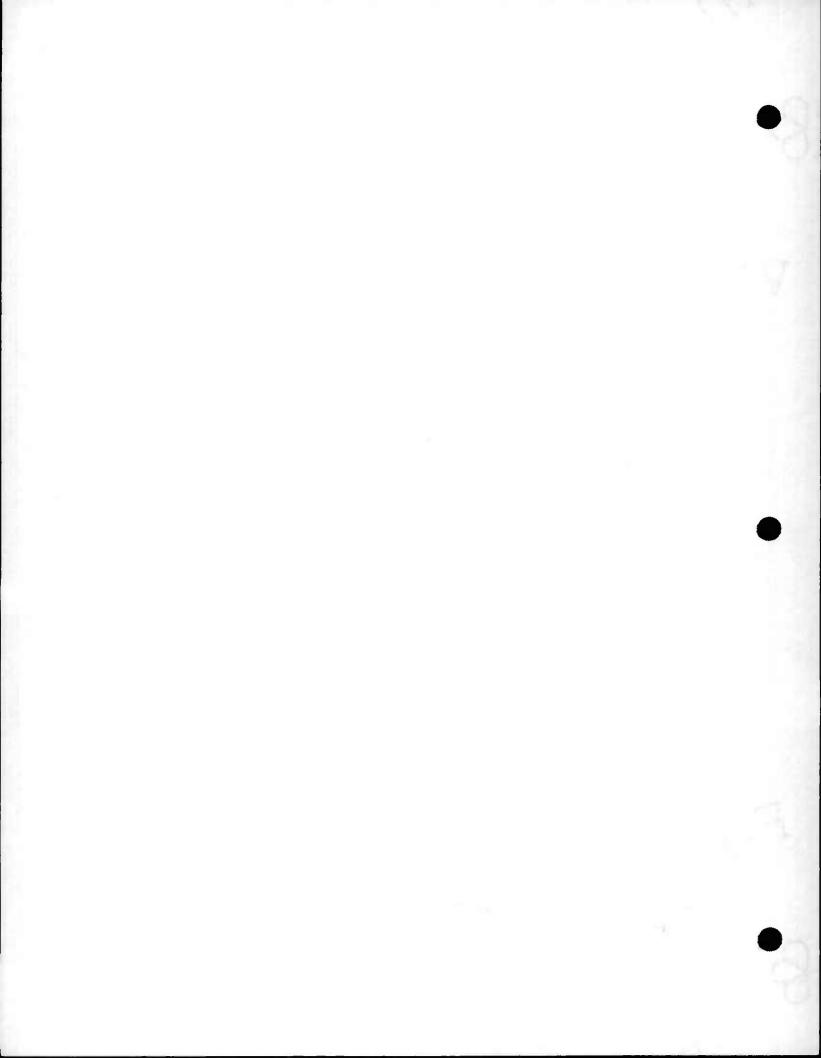
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	1 - STATE REGISTRAR		SIAIE OF I	MARYL	AND / CE	DEPAR	ITMENT (	)F H OF	DEATH AND	MENT	REG. NO.	E			
	1. DECEDENT'S NAME (First,	, Middle, Last)	1=(a)	_						2. DA	TE OF DEATH	v 0	YEAR	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE	In yrs. las	t birthday)	IF UNDER 1 Y		IF UNDER 24 HRS.	7. DA	TE OF BIRTH onth, Day, Year)	1	8. BIRTH	PLACE (State or Foreig	
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	17. FATHER'S NAME (First, MI								16. MOTHER'S NAME (First, Middle, Melden Surneme)						
	Dave Tr	_									rnold				
2	David B. Fl		(Son)		196	MAILING	ADDRESS (St	reet er	Number or Rural	Route No	imber, City or Town	State, Zip			
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	Baltimore Hebrew Cem. 4, 1995 Baltimore, MD  22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Hom											ID			
	VK (	10.	11 7	/	0				M & Russ Win Kno						
CERTIFICATION	DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):														
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			4. SOCIAL SECURITY NUMBER	1000	(In yrs. lest birti	MONTHS	DAYS	IF UNDER 24 HRS. HOURS MIN.	(Mor	E OF BIRTH th, Day, Year)	- 1	8. BIRTHP Country)	LACE (State or Foreig	gn
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t permit.	FINEDAL		10e. STREET AND NUMBER				101	. ZIP CODE			10g. CITIZ	EN OF WI	IAT COUNTRY?	
ransi	Į į		2312 Chetwood Ci					21093				US	A	
IMORE, MARYLAND 21215-0020 Page 6 may be retained by the hospital or attending physician. I director, page 5 should be detached for use as the burial-transit		- 11	1 Never Married 2 Nerried	12. WAS DECEDENT EVER II FORCES? 1 X YES IF YES, GIVE WAR OR D.	2 NO	13.	If yes, sp	ENDENT OF HISPA ecify Cuben, Mexic 2 X NO Spec	an, Puerto		or No-	Black,	- American Indian, White, etc.	
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AND the hospital detached for	once.	5	17. FATHER'S NAME (First, Middle, Lest)	3.	Iraman	Resou	ice	18. MOTNER'S N						_
YL dbe	10 m	ı	John William	Hessian, Jr.				Elizal		_	enson	1		
MAR retained 5 should	TO BY		19e. INFORMANT'S NAME (Type/Print)					and Number or Rural						_
ay be n	be n		Helen T. Hessian						, apt	303,	Timon	ium,	MD 2109	3
6 may	must		20e. METHOD OF DISPOSITION  1  Burlel 2  Cremetion 3  Rea  4  Donetion 5  Other (Specify)	moval from State carr	netery, cramator	y or other place)		ame of	82	,	CATION — C			
Page 6 m	Je.		21. SIGNATURE OF BUNERAL SERVICE L	ICENSEE OO	letro (	Cremato 22		ND ADDRESS OF F	Ma	ay Ca	tonsv	ille	, MD	
ALTI death. P. funeral	examiner	į, li	> Bryan	W. (lar	us		Lemm	on Fune	ral H					
BALTIMO rs after death. Page 6 n by the funeral directs removal.			Bryan M. CI: 23. PART I. Enter the diseases, or		1	Do not control	10 W	. Padon:	ia Ro	ad, Ti	moniu	ım, M		
hours of in l	9		ahock, or heart fellure IMMEDIATE CAUSE (Fine) disease or condition	. List only one ceuse only	ech ine.				on es cei	alec or reepi	ratory arre	est,	Approximete Interval Batw Onset and D	reen
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HYSICIA Nis certi	ै। ≿		27. MANNER OF DEATN	28e. DATE OF INJURY		. TIME OF	28c. INJ	URY AT	_	SCRIBE HOW II	NJURY OCCU	JRED		
DING PHY After this death will	marked BY PI		1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)		INJURY M		RK? /ES 2 NO						
			3 Suicide 8 Could not be 4 Nomicide determined	28e, PLACE OF INJURY building, atc. (Spec	— Al home, fe	erm, atreet, fac	lory, office	•	28f. LOC City	CATION (Street a or Town, State)	nd Number o	r Runal Ros	ite Number,	
DI VISI DR ATTEN DIRECTOR: hours after	ANT: If Item 28 is COMPLETED	1	20. 0507/5/20				,			_				
2 F F	AP I		(Check only 1 X CERTIFYING PNYS	SICIAN: To the best of my knowl										
THE HOSPITAL THE FUNERAL filed within 72 h	<b>8</b> 8		296. SIGNATURE AND THE OF CERTIFIE	ER: On the basis of examination	n end/or invest	igation, in my o	pinion, d			end plece, en	d due to the	ceuse(e)	nd manner ee state	d.
TO THE HOSPIT TO THE FUNERA De filed within 7	BE BE		290. SIGNALUMBAND THE OF CERTIFIE	eid .				29c. LICENSE NU	MBER D 7				Aonth, Day, Year)	
668	≊   ይ	-	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DE	ATN (ITEM 27)	(Type, Print)		007	12/		Ma	y Z,	1995	
6			Anderson M. Reni				, To	wson. Ma	ryla	nd 21	204			
			31. DATE FILED (Month) Day 1941	HEGISTHAR'S SIGN	ATURE			,	,					



DIVISION OF VITAL RECORDS, P.O. BOX 68760

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5	TO THE HOSPITAL OR ATTENDED PHYSICAL TWO Law requires that the death certificate be executed within 24 hours after death. Page	mplete	be filed within 72 hours after comments are Same Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked and them 23 shows any injury, or other traumatic event, the medical examiner r
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DIVISION OF WINE RECORDS, P.O. BOX 68760	be ex	cian a	or to	raum
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	1. DECEDENT'S NAME (First, Middle, Lest)						2. DATE OF	DEATH			3. TIME OF DEATH
		Herre	n				Мау	2 ,	19	95	2:10p 1
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In	yrs. last birthday)			IF UNDER		7. DATE OF E	HOTH		8. BIRTH	PLACE (State or Foreign
	577-01-0485 ¹□м²Д° 80	YRS.	MONTHS	DAYS	HOURS	MIN.	May 2	19	14	Country	rginia
1	8e. FACILITY NAME (If not institution, give street and number)		9b, CITY	, TOWN	OR LOCATI	ON OF D			_	NTY OF DE	EATH
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DIRECTOR	RESIDENCE OF DECEDENT  10a, STATE  10b, COUNTY	100 00	ry, town	20 1 0041	TION!						all transcapping
	Maryland Frederick	100. 01	II, IUWN I								10d. INSIDE CITY LIMITS?
	100. STREET AND NUMBER				Churn				10 017		1 YES 2 NO
FUNERAL	155 N. Carroll Street			100							HAT COUNTRY?
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BE	Grover H. Palmer						lie V.				
2	19a, INFORMANT'S NAME (Type/Print)						Route Number, C				700
	Mr. William J. Herren, Sr.		N. C			tree	et Thu	ırmon			
200	20a. METHOD OF DISPOSITION 1 Disposition 3 Removal from State	PLACE AND DATE	of DISPOS	ITION (Na	me of	_	DATE			City or Tow	
	4 □ Donation 5 □ Other (Specify) FC	ort Line	_				/5/95	Bre	ntwo	od,	MD
	1 1 1				T FU		CILITY AL HOMI	E (P.	O. E	ox 1	95)
	Drian d. Haight		l s	ykes	svil1	le. N	MD 2178	34 (4	10)-	795-	
5	23. PART I. Enter the diseases, or complications that caused shock, or heart failure. List only one cause on each	the deeth. Do	not enter	the mo	de of dy	ing, suc	h es cardlec	or respira	tory arr	est,	Approximata
	IMMEDIATE CAUSE (Final	A	1						7	9	Interval Between Onset and Death
5	disease or condition resulting in deeth)	10 Au	Un	rev	an	4	Cen	re	XX	-	
	QUE TO (OR AS A C	MISEOURICE O	F):			1					2.1.
N N	Sequentially tist conditions,	takic	_ 1	un	S)	00	nee	~ /	ho	-	-34R5
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	ONSEQUENCE OF	1: [	1	41			1			
2 2	CAUSE (Disease or Injury	ond	_ (	ges	7	eq		1.00			
	thet initiated events  resulting in death) LAST	ONSEQUENCE OF	n= (	1		7	()				
訂병				^							
4	PART II. Other algorificent conditions contributing to deeth but	not reaulting	In the un	derlying	ceuse g	jiven in	Part I. 24a	WAS AN AL		24b.	WERE AUTOPSY FINDINGS
MEDICAL	as Ihmalic Di	ronc	th	il	La		1.5	PERFORM	-		AVAILABLE PRIOR TO COMPLETION OF CAUSE
							_ [	160 1	, 110		OF DEATH?
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF	DEATH YE	SDI	NO [	UNC	ERTAIN	VIE				10 100 2
ĭ   ₹	25. WAS CASE REFERRED TO MEDICAL 26	. PLACE OF DEA									
PHYSICIAN:	1 YES 2 HOSPITAL: 1 Inpatient 2 ER/Outpat	lent 3 DOA	OTHER		5 11/16	sidence	8 Other (Spi	eclfv)			
ΙĘ	27. MANNER OF DEATH 28e. DATE DF INJURY (Month, Day, Year)	28b. TIM	-	28c, INJ			28d. DESCRIE		URY OCC	CURED	
BY	1 Natural 5 Pending 2 Accident Investigation		M	-	ES 2	ON					
EDE	3 Suicide 8 Could not be 28e. PLACE OF INJURY — building, atc. (Specify	At home, farm,	street, tact	ory, office			28f. LOCATION	V (Street and	Number	or Aurel Ac	oute Number,
	4 Homicide determined						Only or 101	··· Guille)			
P. 1	29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowled	ige, death occurr	ed at the ti	me, date	and place,	end due	to the cause(e)	end manne	r ee state	ed.	
COMPLET	MEDICAL EXAMINER: On the basis of exemination a										and menner as stated.
U U	291, SIGNATURE AND TITLE OF GENTIFIER	1				NSE NUM			_		Mjorith, Day, Ward
	Van Xali) (a	2021	14000	7	00	71-7	21	1.5	h 5	-/-	10-

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

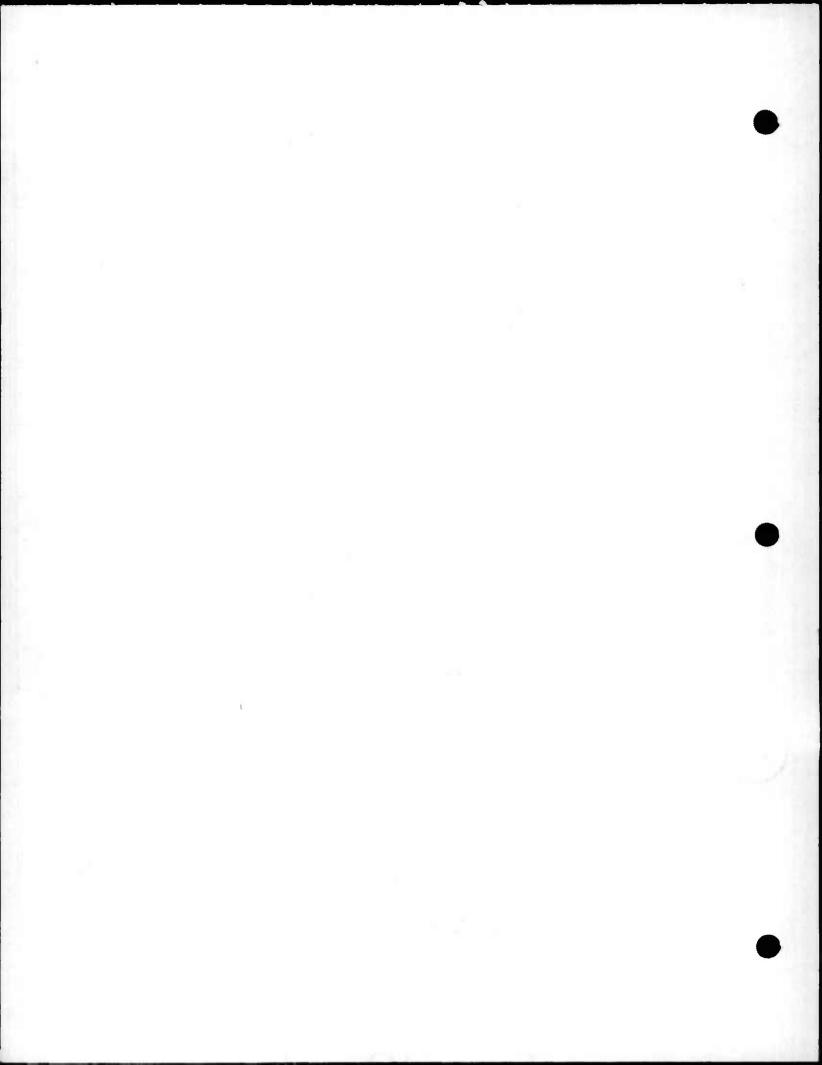
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	1 - FOR STATE REGISTRAR	STATE OF MARYLA	AND / DI	EPARTMI RTIFICA	NT OF H	EALTH AND	MENTA	NL HYGIEN			
	1. OECEDENT'S NAME (First, Middle, Lest) ESTELLE HAYES			27.7			2. DAT	e of OEATN	y ₅	EAR	3. TIME OF DEATH 10:12 A
	4. SOCIAL SECURITY NUMBER 218–16–1009	5. SEX 6. AGE (/	n yrs. last bir	thday) IF U	HS DAYS	IF UNDER 24 HRS HOURS MIN.	7 DATE	OF BIRTH		BIRTNI	PLACE (State or Foreign
æ	9a. FACILITY NAME (If not institution, give st	treet and number)	70	9b.		OR LOCATION OF		111 13,1	9c. COUNTY		
010	FRANKLIN SQUARE H			В	ALTIMO	RE			BALT	IMOI	RE
. DIRECTOR		TIMORE		ESSEX	VN OR LOCAT	ION					10d. INSIDE CITY LIMITS? 11 YES 2 NO
FUNERAL	2 ENSIGN COURT					21221			UNITE		TATES
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEOENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR OA	2 T NO		If yes, spi	ENDENT OF NISI ecity Cuban, Max 2 NO Spe	ican, Puarto	IN? (Specify Yea Rican, etc.)	or No- 14	Specif	- American Indian, , White, atc. y: BLACK
COMPLETED	15. DECEDENT'S EQUE (Specify only highest grade  Elementary/Secondary (0-12)		(Give I				16	PRIVAT		TRY	
	17. FATHER'S NAME (First, Middle, Last) OSCAR WATKINS					18. MOTHER'S			Surname)		
TO BE	190. INFORMANT'S NAME (Type/Print) PRISCILLA PRYER					nd Number or Rur		nber, City or Town		ide)	
	PRISCILLA PRYER  2 ENSIGN COURT ESSEX, MD 21221  20e. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, cramatory) AFRICATION CEMETERY  20c. LOCATION - City of Town, State cemetary, cramatory) AFRICATION CEMETERY  5-6-95 BALTIMORE, MD										
	22. NAME AND ADDRESS OF FACILITY 270 FREDHILTON CALVIN L. WILLIAMS F.S. BALTO., MD 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory strest, Approximately 1.										
SATION	23. PART I. Enter the diseases, or o shock, or heert failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cause on es	ch line.								Approximate interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST	o. Enter UNDERLYING E (Disease or Injury Initiated events  Due to (or as a consequence of:  30 y  Due to (or as a consequence of:  Due to (or as a consequence of:  Due to (or as a consequence of:  Due to (or as a consequence of:  Due to (or as a consequence of:									
AL.	PART II. Other aignificent condition	e contributing to deeth bu	it not reeu	ilting in the	underlying	cause given	in Part I.	24a, WAS AN PERFOR 1 YES 2	MEO?		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
: MEDICAL CI	DID TOBACCO USE CONTR	PIRLITE TO CALISE OF	E DEATH	VEC TO		UNCERTA	JAL 🗖		,	1	1 TES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		_	F DEATH (Ch	eck only one)	OIACERIA		l			
HYSI	1 TYES 2 5 NO  27. MANNER OF DEATH	1 ☐ Inpatient 2 ☐ ER/Outpa 26a, DATE OF INJURY			Nursing Nome	5 Residenc		er (Specify) SCRIBE NOW IN	HIBY OCCUP	SED.	
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	1	INJURY	1 D Y	RK? ES 2 NO	200. 02	JOHNSE HOW II	WONT OCCUM	CU	
	3 Suicide 6 Could not be 4 Homicide detarmined	26a. PLACE OF INJURY building, atc. (Speci	— At home,	farm, street,	factory, offica		261. LOS City	CATION (Street a or Yown, State)	and Number or	Rurel Ro	oute Number,
COMPLETED		CIAN: To the beat of my knowledge: On the basis of examination								ause(a)	end manner as stated.
96	29b. SIGNATURE AND TITLE OF CERTIFIER		-			29c. LICENSE N					(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27		irles	Sta	101/	Ω (	J	1/	11 01 212011
	31. OATE FILED (Month, Day, Year)	REGISTRARIS SIGNA	RE .	- VIC	グリセン	91,0	116	2 100	TIMO	101	201

DA-Armer Inn

31. DATE FILED (Month, Day, Year)

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32. REGISTAR'S SIGNATURE

HE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1. 2. 3 should	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
THE HOSP	THE FUNE	e filed within	MPORTANT

	FilmG, 72.	3, lte			- th							90		3303	
	FOR STATE REGISTRAR		STATE OF I	/ MARYLAND /	DEPAR	RTMENT	OF H	EALTH	AND I		HYGIEN	E			
	1. DECEDENT'S NAME (First,	Middle, Last)				TOATE		DEA	-	2. DATE OF			$\overline{}$	3. TIME OF DEATH	
	IOHN ANTHO	WV	инсе							MAY	DA 1	MA.	1995	06:30	
	10HN ANTHO		HUSS 5. SEX	6. AGE (In yrs. les	t histholms)	IF UNDER	1 VEAD	# UNDER	na tene	7. DATE OF	1				
			1 (X M 2   F			MONTHS	DAYS	HOURS	MIN.	(Month, I	Day, Year)		8. BIRTHE	PLACE (State or Forei	ign
	390-36-7769			59	YRS.					June	13, 1	935	Wis	sconsin	
_	9a. FACILITY NAME (If not ins	titution, give st	treet and number)			9b. CITY	TOWN C	R LOCATION	ON OF DE	ATH		9c. COL	JNTY OF DE	ATH	
O	GREATER BAI	TIMOR	F MEDICA	L CENTER	}	ТО	WSON					BA	LTIMO	ORE	
DIRECTOR	RESIDENCE OF DEC														
H	10a. STATE	10b. COUNTY	•		10c. CIT	Y, TOWN	OR LOCAT	ION						10d. INSIDE CITY LIMITS?	
	Maryland		Baltimor	e		Timo	<u>n</u> ium							1 - YES 2 X NO	0
AL	10e. STREET AND NUMBER						101	ZIP CODE	E			10g. CIT	IZEN OF W	HAT COUNTRY?	
FUNERAL	40 Faraday I	rive						21	093				US	SA	
5	11. MARITAL STATUS			IT EVER IN U.S. AR		13.	WAS OEC	ENDENT C	F HISPAN	IIC ORIGIN?	Specify Yea	or No-	14. RACE	- American Indian.	,
	1 Never Married 2 1		IF YES, GIVE	YES 2 N	10			2 X NO		n, Puerto Ric	en, atc.)		Specify	White, etc.	
В	3 Widowed 4 X Olvon	ced	1971	-1978				24					Opening	White	
		DENT'S EDUC		16a, DE	CEOENT'S	USUAL O	CCUPATIO	N		16b, K	IND OF BUS	SINESS/IN	DUSTRY		
1	Elementary/Secondary (0-		College (1-4 or 5	t) Via	Do NOT u	se retired.)	ounng mo:	Door	9						
릴	12		5+	Fide	lity	se retired.) S. N & S	uret	A	OH		U	.S.F	. &G.		
COMPLETED	17. FATHER'S NAME (First, Mic	ddle, Last)								ME (First, Mic	dle, Maiden	Sumame)			
BE C	John		W.	Huss					Lois	F.	rspal	mer			
	19a. INFORMANT'S NAME (Ty	pe/Print)				ADORES!	(Street a			Route Number,			p Code)		
2	Sharon A. Ho	fmeis	ter							nium,		2109			
	20e METHOD OF DISPOSITION			20b. PLACE					1 I IIIO		7		City or Tow	en State	
	1 ☑XBurial 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (	n 3 🗌 Remo	oval from State	cametery, cre	matory or o	ther place)				04 May	Ti	Timo	nium	faryland	
	21. SIGNATURE OF UNERAL	1	ENSES /	Trulan	ey v			D ADDRES			12:00	MINIT	um, r.	aryranu	
	DU	Han	W.1°V	arus			Le	mmon	Fun	eral :	Home				
	Bryan W						10	W.	Pado	nia R	oad,	Timo	nium,	MD 2109	3
	23. PART I. Enter the dis	eses, or c	complications the	t coused the de	eth. Do	not enter	the mo	de of dyl	ng, suc	h es cardie	c or raspl	ratory er	rest,	Approximate	
- 1	IMMEDIATE CAUSE (Fine													Onset and D	
1	disease or condition resulting in death)	•	Vent	cicular	Fil	ocilli	ation	4						Minute	
	resulting in death)		. Vent	(OR AS A CONSEC	DUENCE O	F):								10 1101	
2			Myo	cardia	1	Traf	arc	tin.	Λ					1	
CERTIFICATION	Sequentially list condition if any, leeding to immed	ons,	OUE TO	(OR AS A CONSEC	UENCE O	F):	-		-1-						
X	ceuse. Enter UNDERLYIN	IG													
Ĕ	CAUSE (Disease or Injur that initiated events	y ) '	DUE TO	(OR AS A CONSEC	OUENCE O	F):								1	
F	resulting in death) LAST													-	
빙		-												1	
A	PART II. Other significer	nt condition	s contributing to	deeth but not r	eeuiting	in the un	derlying	ceuse g	iven in	Part I. 2	ea. WAS AN	AUTOPSY		WERE AUTOPSY FINO	
5										_	YES 2			AVAILABLE PRIOR TO COMPLETION OF CAU	
MEDICA												-		OF DEATH?  1 YES 2 NO	. 1
	DID TOBACCO US	SE CONTR	RIBUTE TO CA	USE OF DEA	TH Y	SIL	VO X	LINC	ERTAIN					TES 2 DE RO	
A	25. WAS CASE REFERRED TO		WOOTE TO CA		_	TH (Check		0110	LICIAN	, 0 1					_
2	EXAMINER?		HOSPITAL:	/		OTHER	1:								
PHYSICIAN:	27. MANNER OF DEATH		28a. DATE OF		28b. TIM		28c. INJ	_	sidenca	6 Other (S		IIIBY OC	CHRED		-
	1 Netural 5 P	ending	(Month, E	lay, Year)	IN.	URY	WO	RK?	۱ ۵۰۰	200. DESCR	IIDE HOW II	SONT OC	CONED		
B	2 ALCHONIA	rvestigation	20n PLACE C	F INJURY — At ho					) NO						
		ould not be etermined	building,	etc. (Specify)	ire, term,	street, race	ory, ornica				Town, State)	na Numbe	r or Rural Ro	oute Number,	
ᄪ	25a CENTIFIER		<del></del>												
릴	(Check got) CERTI	FYING PHYSIC		my knowledge, de											
COMPLETED	2 MEDIC	TEXAME	R: On the beals of a	xamination and/or i	nvestigatio	on, in my o	pinion, de	eath occur	ed at the	time, data ar	d place, and	d due to ti	ne cause(s)	and manner as state	ed,
	296. SIGNATURE AND THE	OF CHICIFIER	4					29c. LICE	NSE NUN	IBER	. 1	29d. DAT	E SIGNED	Month, Day, Year)	
BE	/ an .	1	Jun					D	-17	104	1			, 1995	
유	30. NAME AND AGORESS	PERSON WHO	O COMPLETEO CAU	SE OF OEATH (ITER	4 27) (Type	Print)		17	- (	-			.ruy Z	, 1773	-
ļ		-	.D. 7600				117501	n M	2 277 1	and '	21204				J

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		1 - FOR STATE REGISTRAR	STATE OF MARY					HEALTH AND DEATH	MENTA	AL HYGIEN	E		
		1. DECEDENT'S NAME (First, Middle, Last)  Cecelia	NMN		Hol				2. DAT	E OF DEATH	995	YEAR 3	. TIME OF DEATH
o o		4. SOCIAL SECURITY NUMBER 220-12-7085 A	5. SEX 6. AG	E (In yrs. les	t birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DAT	E OF BIRTH	17	. BIRTHPL Country) IARYI	ACE (State or Foreign
2, 3 should	стоя	90. FACILITY NAME (If not institution, give str Dulaney Towson N		<u> </u>			WSO	OR LOCATION OF D	EATH	1	9c. COUNT BALT IN		тн
Pages 1,	DIREC	RESIDENCE OF DECEDENT  10a. STATE  MARYLAND  BALT	IMORE			Y, TOWN C		TION			- 1	Dd. INSIDE CITY	
if permit.		100. STREET AND NUMBER  111 We				TOWSO	10	1. ZIP CODE					YES 2 1 NO
attending physician.	BY FUNERAL	11. MARITAL STATUS  1 Never Married 2 Merried  3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2 1			WAS DEC	1204 CENDENT OF HISPA ecity Cuben, Maxici 2  Specia	an, Puarto	IN? (Specify Yee Rican, atc.)	USA or No-		
. 6 .	LETED	15. DECEOENT'S EOUC (Specify only highest grade of Elementary/Secondery (0-12)	College (1-4 or 5+)	(G	CEDENT'S ive kind of a	work done	CCUPATE during mo	ON st of working	16	b. KIND OF BUS	SINESS/INDU		HITE
YLAND of the hospital be detached for at once.	COMPL	17. FATHER'S NAME (First, Middle, Last)	N/A	_	18. MOTHER'S NA		Own Hor						
A Pe Pe	H	George 196. INFORMANT'S NAME (Type/Print)	Schrufer	ADDRESS	Mary			n, State, Zip C	ode)				
5 5	٩	Linda Boyce	inda Boyce 19625 Burke Rd., White Hall, MD 21161										
death. Page 6 may be tuneral director, page		1 Neurial 2 Cremation 3 Remo 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIG	val from State	emetery cre	Ride	ther place) ge Ce	met	ery			canon – ci		
		22. NAME AND ADDRESS OF FACILITY  10 W. Padonia Rd.  Timonium MD 21093  23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory streat, Approximate											
in 24 hours after shy filled in by the nation, or removal the medical		IMMEDIATE CAUSE (Finel											
ecuted within nd complete burial, crema attic event,		DUE TO (OR AS A CONSEQUENCE OF):											2 days
<b>2</b> 2 2 6 8	SATION	Sequentially list conditiona, if any, leading to immediata ceuse. Enter UNDERLYING	DUE TO (OR AS	A CONSEC	DUENCE OI	7):							2 days
anding p	CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	OUE TO (OR AS	A CONSEC	DUENCE OI	F):							
w requires that the deal been signed by the attr pt. of Health and Memal <b>3 shows any Injury</b> ,	MEDICAL (	PART II. Other significant conditions Denile Demential		but not re	naulting I	n the un	derlying	g cause given in	Part I.	24a. WAS AN PERFOR	MED?	AA CC	ERE AUTOPSY FINDINGS MILABLE PRIOR TO DMPLETION DF CAUSE F DEATH?  YES 2 (FC NO
he law req has been p Dept. of		DID TOBACCO USE CONTR	IBUTE TO CAUSE		TH YE			UNCERTAI	N□	1.7			
SICIAN: The certificate h the State i	YSICIAN:	EXAMINER? 1 VES 2 NO	HOSPITAL:			OTHER	1:	e 5 🗆 Residenca	8 🗆 Oth	er (Specify)			
ATTENDING PHYSICIAN: The law ECTOR: After this certificate has be after death with the State Dept. 28 is marked, or item 23	ВУ РНУ	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)		28b. TIM INJ	E OF URY M		URY AT RK? /ES 2 NO	28d. DE	SCRIBE HOW IN	JURY OCCU	RED	
OR ATTENDIN DIRECTOR: Aft hours after de	ETED I	3 Suicide 8 Could not be determined	28s. PLACE OF INJUI building, etc. (Sp	RY — At hou	me, ferm, s	treet, fect	ory, office	•	281. LOI City	CATION (Street at or Town, Stete)	nd Number or	Rural Rou	e Number,
# 25 km	COMPLI	29a. CERTIFIER (Check only one) 1 M CERTIFYING PHYSIC MEDICAL EXAMINER	IAN: To the best of my kno	owledge, de lon end/or l	ath occurre	od at the ti	me, date pinion, d	end place, and dua	to the ce	use(e) and man	ner es stated	:euse(a) a	nd menner ee stated.
물 물을 통	29b. SIGNATURE AND TITLE OF CERTIFIER							29c. LICENSE NUMBER  DO \$583  29d. DATE SIGNED (Month, Day, You)  5/4/95					onth, Day, Year)
2633	2	30. NAME AND ADDRESS OF PERSON WHO		AF 4711 (1754		01.0		20 03	00		-	-14	195

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

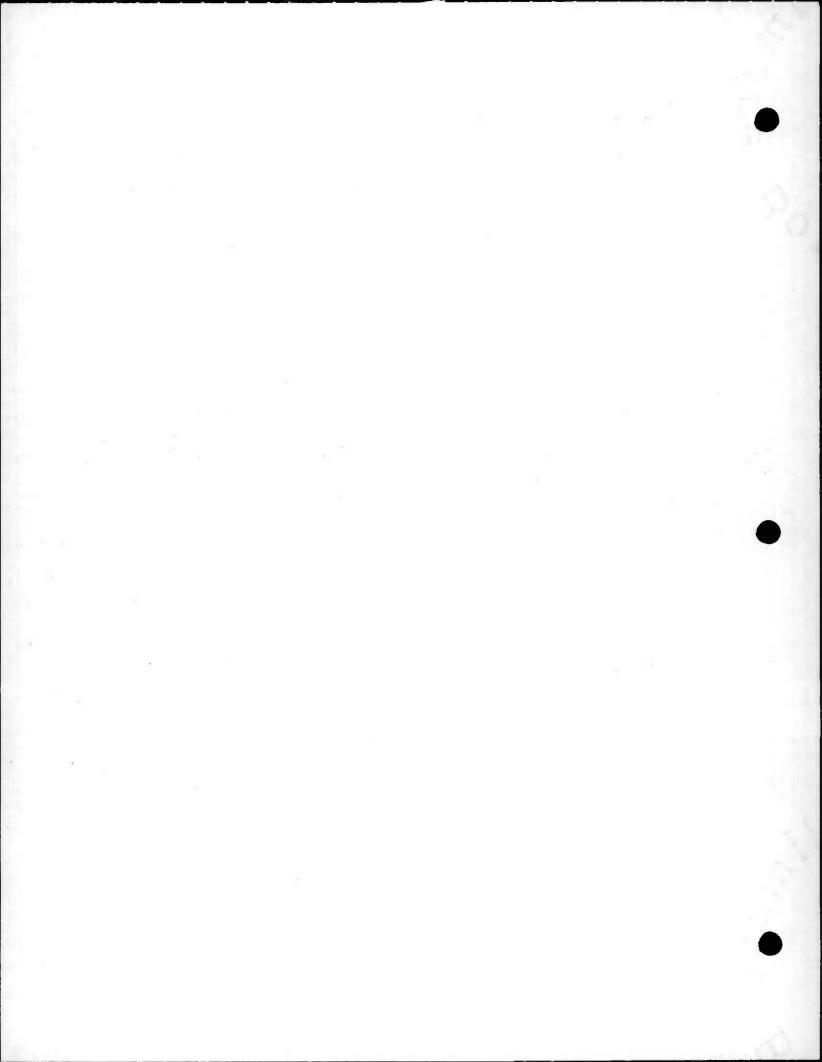
M.D.,

William Benedict,

G. William

31. DATE FILED (Month). Day 30.20
MAY 0 4 1995

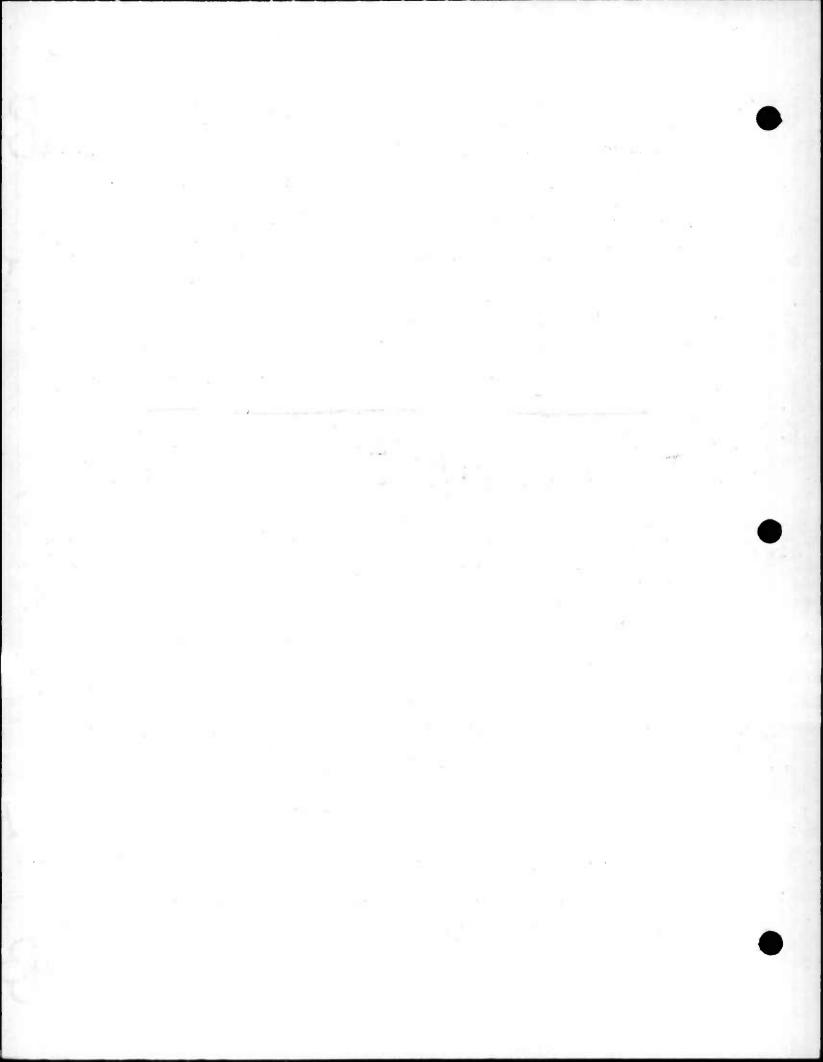
GBMC Physician's Pav. E, Suite 209, Towson, MD 21204



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle Leat) 2. DATE OF DEATH 3. TIME OF DEATH William Johnson, III Α. May 1995 6:08 D.M 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign Country) 214-12-2932 1 X M 2 T F 75 1920 Maryland Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 5904 Winthrope Avenue Baltimore City N/A RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY N/A Maryland Baltimore City permit. 1 X YES 2 | NO 10a. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit o burial, cremation, or removal. 5904 Winthrope Avenue 21206 United States hours after death. Page 6 may be retained by the hospital or attending physician. 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexicen, Puerto Rican, stc.) 14. RACE — American Indian, Black, White, etc. If yes, specify Cube 1 ☐ YES 2 💢 NO 1 Never Married 2 Married Korean or Conflict BY 3 Widowed 4 Divorced Specify: White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Salesman Auto 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) te William A. Johnson Gertrude E. Fitzsimmon BE notified 190. INFORMANT'S NAME LOT Talne 196. MAILING ADDRESS .5904 Winthrope Avenue Baltimore, Md 21206 Mac Dougall 9 -221 East Northern Pkwv Voelker Dorothy M. 21212 Pe 20a. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of must DATE 20c. LOCATION - City or Town, State 1 Burlel 2 X Cremetion 3 Rem Hilltop Service Corp. 4 Donation 5 Other (Specify) 5/6/95 Towson, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Milton J Knight Jr Leonard J. Ruck, Inc. Baltimore, Md. 21214 5305 Harford Road medicai 23. PART I. Enter the diseases, or complications II the deeth. Do not enter the mode of dying, such as cerdlec or respiratory arrest, shock, or heart fellure. Liet only one cremation, or interval Between **IMMEDIATE CAUSE (Fine)** Onaat and Death event, the Cardiac Quest disease or condition 2 Min resulting in death) executed with 2 main status traumatic CERTIFICATION Sequentially list conditions, 20 DUE TO (OR AS A CONSEQUENCE OF): been signed by the attending physician and Nental Hygiene prior to if sny, lesding to immediate death certificate be Cause. Enter UNDERLYING CAUSE (Disesse or Injury other DUE TO (OR AS A CONSEQUENCE OF): thet initieted events resulting in death) LAST 10 PART ii. Other significent conditions contributing to death but not recuiting in the underlying ceuse given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATN? 24s. WAS AN AUTOPSY shows any 1 TYES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES X NO UNCERTAIN U PHYSICIAN: has b. Dept. OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? certificate I HOSPITAL:
1 | Inpatient 2 | ER/Outpetient 3 | DOA OTHER 4 Nursing Home 5 A Residence 6 Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? marked, 286. TIME OF 26d, DESCRIBE HOW INJURY OCCURED this c 1 Natural 2 Accident 5 Pending Investigation 1 YES 2 NO BY After 26e. PLACE OF INJURY — At home, ferm, street, tectory, office building, etc. (Specify) 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 10 6 Could not be DIRECTOR: / COMPLETED 4 Homicide 28 determined Item 29a. CERTIFIER CENTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner se stated. TO THE HOSPITAL O
TO THE FUNERAL D
De filed within 72 ho
IMPORTANT: If Its MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated. BE 29d. DATE SIGNED (Month Day, Year) mon 2 SS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Baltimore, Md. University Hospital John W. Ames M.D. 32. REGISTRAR'S SIGNATURE Studier Rad 0 4 1995



BALTIMORE, MARYLAND 21215-0020	hours the death. Page 6 may be retained by the hospital or attending physician.	his certificate has been signed by the attending physician and competitely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
DIVISION OF VILAL RECORDS, P.O. BOX 68760	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate he executed within 24 hours after death. Page 8 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and compatibly filled in by the be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burtal, cremation, or removal.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AT CERTIFICATE OF DEATH		
	1. DECEDENT'S NAME (First, Middle, Last)  ERNEST JOHNSON	2. DATE OF DEATH DAY APRIL 30	YEAR 02:30 AM
	1271-70-07-77 1 A M 2 U F 80 YRS.		8. BIRTHPLACE (State or Foreign outling)
DIRECTOR	96. FACILITY NAME (If not institution, give street and property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the property of the propert	OF DEATH 9c. COUN	TY OF DEATH
	10a. STATE  10b. COUNTY  10c. CITY, TOWN OR LOCATION  PAITINGES  10c. CITY, TOWN OR LOCATION  10d. TIP CODE		10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	508 N. ARLINGTON AVE 212	223 6	( ) A
æ			14. RACE — American Indian, Black, White, etc.
APLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary(Secondary (0-12)  College (1-4 or 5+)  16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	B+O RAI	POAD
I at once.		R'S NAME (First, Middle, Melden Surname)	en/
TO BE	19a. INFORMANT'S NAME (Type/Print)  19b. MAILING ADDRESS (Signal and Number or HIO) HIDER	Rural Route Number, City or Town, State, Zip	Code)
must be	20s. MCTHOD OF DISPOSITION  1	SISIAS ANDITION	City or Town, State
examiner	21. BIGHATURE OF PROFITAL SERVICE LICENSEE  22. MINE AND ADDRESS  ARY  1. TR. 5.1	WITH FUNETO	HOME PAI
ent, the medical	23. PART Letter the diseases, or complications that caused the death. Do not enter the mode of dying thock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)  a. CARDIOGENIC SHOCK  DUE TO (OR AS A CONSCOUENCE OF):	, such as cardiac or respiratory arre	Approximate Interval Between Oneat and Death
CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	4RETION	IDAY
or othe	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):  resulting in death) LAST		
shows any injury, : MEDICAL CI	PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause give	en in Part I.  24a. WAS AN AUTOPSY PERFORMED?  1 □ YES 2 NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO
2 Z	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCER  25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)	RTAIN 🛭	1 125 2/410
or item YSICI	EXAMINER?  1 YES 2 NO  HOSPITAL: 1 Inputient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Reside	ence 8 Other (Specify)	
marked, or BY PHY	27. MANNER OF DEATH  28a. DATE OF INJURY (Month, Day, Year)  28b. TIME OF INJURY AT WORK?  M 1 YES 2 N	28d. DESCRIBE HOW INJURY OCCI	JRED
28 is TED	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, term, street, tactory, office building, atc. (Specify)	281. LOCATION (Street and Number of City or Town, State)	or Rural Route Number,
MP I	29a. CERTIFIER (Check only one)  2 MEDICAL EXAMINER: On the basis of my knowledge, death occurred at the time, date and place, and one)  2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one)	d due to the cause(a) and manner as state at the time, data and place, and due to the	d. cause(a) and manner as stated.
TO BE COI	290. SIGNATURE AND TITLE OF CERTIFIER  290. LICENSI  30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (King Print)	2060 P	SIGNED (Month, Day, Year)
F	GILBERT CHIBIAC, SAINT AGARS HOSP. 900 CA	FON ME. BATTI	70RE, MD, 21229
	MAY U 4 1995 julia devoter Revolt		

VEAR

9c. COUNTY OF DEATH

3. TIME OF DEATH

10d. INSIDE CITY

14. RACE — American Indien, Black, White, atc.

Spurrier

1X YES 2 NO

6. BIRTHPLACE (State or Formign

Maryland

10g. CITIZEN OF WHAT COUNTRY?

Specify: Caucasian

United States

Home

7:18 p.m. M

2. DATE OF DEATH Josephine Marie Kellner 1995 4. SOCIAL SECURITY NUMBER 218-May 1, 6. AGE (In yrs. lest birthday) S. SEX IF UNDER 24 HRS. 7. DATE OF BIRTH 800-03-8655-7776 80 DAYS April Day 9 1915 1 M 2 X F Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 2222 Pelham Avenue Baltimore City RESIDENCE OF DECEDENT 10a, STATE 10h. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Baltimore City permit. FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 2222 Pelham Avenue funeral director, page 5 should be detached for use as the burial-transit 21213 Page 6 may be retained by the hospital or attending physician. 11 MADITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2XXNO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, atc.) BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married If yes, specify Cube
1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES BY 3 Wildowed 4 Divorced Specify: 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Year Housewife once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surname) notified at BE John Adam Fink Millie Berry 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Catherine B. Hedges 154 Kingston Park Lane Baltimore, MD 99 20e. METHOD OF DISPOSITION

12 Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of must Most Holy Redeemer Cem. 4 Donation 5 Other (Specify) 5/4 21. SIGNATUBE OF FUNERAL SERVICE LICENSEE examiner 22 NAME AND ADDRESS OF FACILITY
Loring Byers Funeral Directors, INC. hours after death. 8728 Liberty Rd Randallstown, MD 21133-4784 and completely filled in by the burial, cremation, or removal. medical 23. PART I. Enter the diseases, Dr complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, ahock, or heert feilura. Liet only one cause on each line. IMMEDIATE CAUSE (Fine) disease Dr condition_ CONONAM ATTO sor dem event. reaulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 traumatic CERTIFICATION Sequentially list conditions, prior to DUE TO (OR AS A CONSEQUENCE DE) if any, leading to immediate cause. Enter UNDERLYING physician CAUSE (Disease or injury the attending phy 1 Mental Hygiene p DUE TO (OR AS A CONSEQUENCE OF): that initieted eventa resulting in death) LAST Injury, PART II. Other aignificant conditions contributing to deeth but not reculting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL signed by the апу 1 TYES 2 NO shows a DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WOLCERTAIN PHYSICIAN: has b. Dept. WE 8 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) DR ATTENDING PHYSICIAN: The I DIRECTOR: After this certificate ha hours after death with the State Di **EXAMINER?** OTHER: 1 YES 2 KNO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Masidence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 26c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, 1. Natural (Month, Day, Year) 5 Pending 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, term, street, tectory, office building, stc. (Specify) 3 Sulcide 28 Is COMPLETED 6 Could not be 4 Homicide item 29e. CERTIFIER
(Check only one)

2 MEDICAL SYMMISS. On the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) and manner ea stated. FUNERAL Within 72 h HOSPITAL = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated 296. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER BE 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

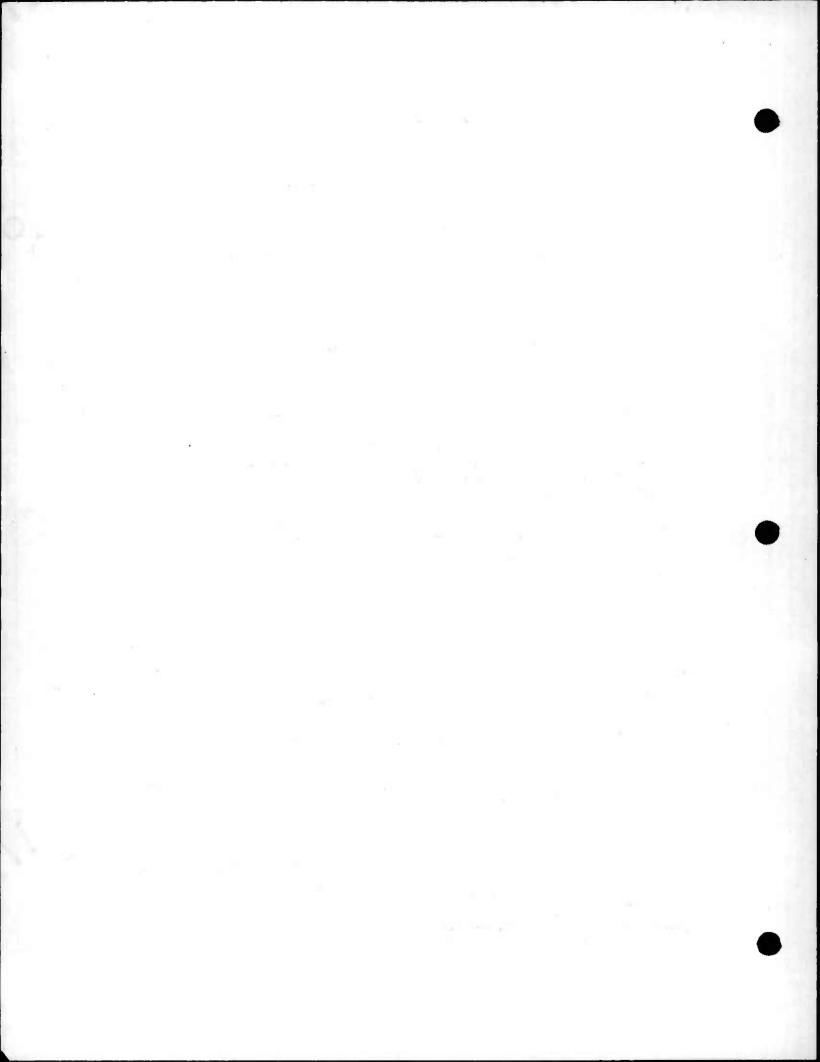
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1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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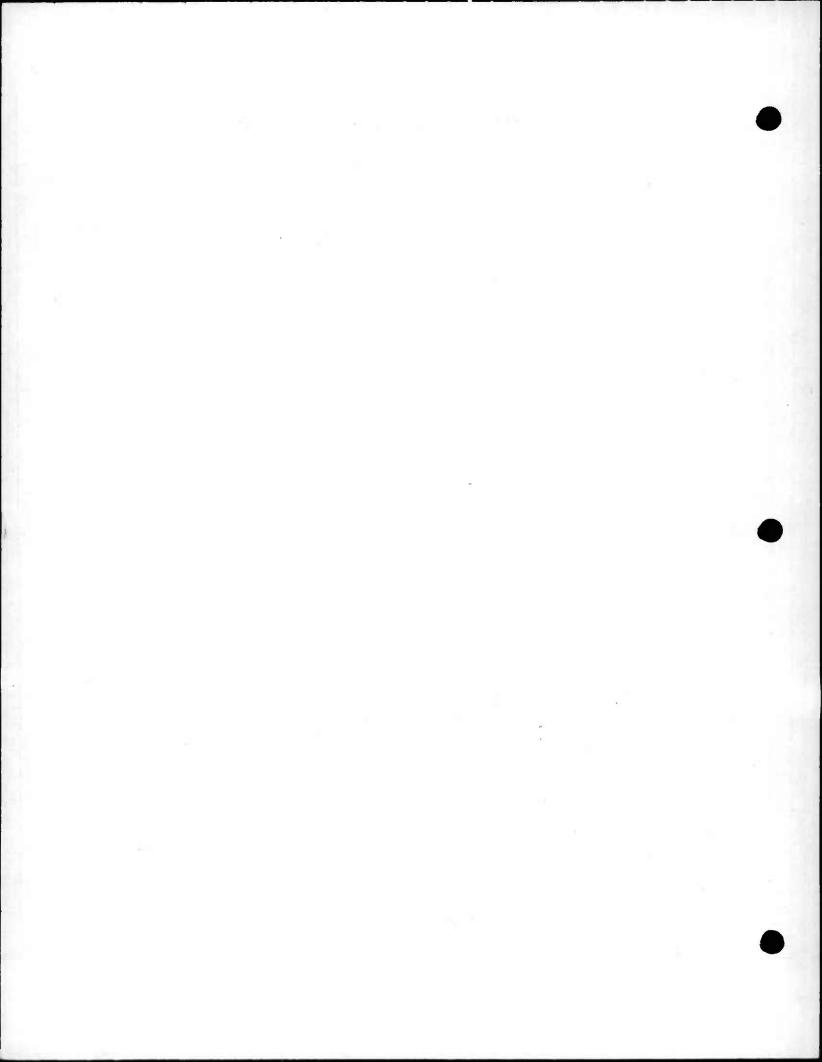
20c. LOCATION - City or Town, State Baltimore, MD Approximate Intervel Between **Onset and Death** 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) DHMH-16 Ray 1/89



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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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		1. DECEDENT'S NAME (First, Middle, Last)	S	1	1.	2. DAT	E OF OEATH	3. TIME OF DEATH
			Damuel	L, 1	Kina	An	ni 25, 19	95 10:15 PM
		4. SOCIAL SECURITY NUMBER	, , , , , , , , , , , , , , , , , , , ,	Ca	IF UNDER 1 YEAR IF UNDER	(4.4-	E OF BIRTH 8.	BIRTHPLACE (State or Foreign Country)
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3 should	ا ش	Sa. FACILITY NAME (If not institution, give :	street and number)	7	96. CITY, TOWN OR LOCAT	TION OF DEATH	9c. COUNTY	Y OF DEATH
1, 2,	DIRECTOR	RESIDENCE OF DECEDENT	Ville F	fire	Daltino	ore		NA
	35	10a. STATE 10b. COUNT	Υ ,	10c. CITY,	TOWN OR LOCATION			10d. INSIDE CITY
permit. Pages	ā	Mg	NA	Ba	Himore			1 YES 2 NO
регт	\¥	10e. STREET AND NUMBER	// //		10f. ZIP COI		10g. CITIZE	N OF WHAT COUNTRY?
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21215-0020 al or attending physic for use as the burial	B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D		1 TES 2 NO		ricent, etc.)	Specify 2/2 M
1215-0 or attending use as the		15. DECEDENT'S EDU	6-25-42	18a. DECEDENT'S US	7		The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon	Diane
212 or at	COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	completed)	(Give kind of wo	rk done during most of work	ting	b. KIND OF BUSINESS/INDUS	TRY
	립	3rd Grade	College (1-4 or 5+) UhRA OHIO		unkno	ut.		unknown
the hospital of detached for once.	S S	17. FATHER'S NAME (First, Middle, Last)					Middle, Malden Surname)	- Granding
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MARYLAND  retained by the hospit  s should be detached  notified at once.	8	19a. INFORMANT'S NAME (Type(Print)	011	19b. MAILING A	DDRESS Street and Number	er or Rural Route Nui	nber, City or Town, State, Zip Co	ode) 4
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BALTIMORE, er death. Page 6 may be the funeral director, page val. ii examiner must be		20a. METHOD OF DISPOSITION 1 Burlat 2 Cremation 3 Rem	20b	PLACE AND OATE OF	DISPOSITION (Name of	DA	TE 200 COCATION - CIN	y or Town, State
ALTIMORE, death. Page 6 may be funeral director, page t. examiner must be		✓ □ Donation 5 □ Other (Specify)		etery, overnatory or other	on torest	Vet 5k	195 Owing.	s Mills Md
TIN Page		21. SIGNATURE OF PANERAL SERVICE LIC	CENSEE		22. NAME AND ADDRE	ESS OF FACILITY	last	
ALTIN death. Pag e funeral dir d. examiner		* Alle Wistela	Yordun_		March	1 H. W	Rosh Nero	
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- hour	1	ahock, or heart failure.	Liet only Dne cause on e	ech iine.		,	and or respiratory arrest	Intarval Between
within 24 ho npietely filled cremation, o		disease or condition	Moto	exton t	C. NO	10-	1 Carco	Onast and Death
od within 24 ompletely fill cremation, event, the		resulting in death)	DUE TO (OR AS A	CONSEQUENCE OF):	10 16	u	Carco	WITE
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× 8 5 2 5	은	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):	· · · · · · · · · · · · · · · · · · ·			
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다 등 등 등 등	EH	resulting in death) LAST	d					
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	🕺	PART II. Other aignificent condition	is contributing to deeth b	ut not resulting in	the underiving cause	given in Part I.	24a WAS AN AUTOPSY	245 WERE ALTTORSY EINDINGS
DRC that the day day and and		PART II. Other aignificent condition	s contributing to deeth b	ut not resulting in	the underlying ceuse	given in Part i.	24s. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE
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AL REC I law requires has been sign Dept. of Heal	MEC	DID TOBACCO USE CONT. 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUSE O		□ NO □ UNG	given in Part I.	PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF M	ARYLAND /	DEPAR ERTIF	TMEN	T OF H	EALTH DEAT	AND I	MENT	AL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last) SHIRLEY			-	KEL	LER			MOI		AY CO.F	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t hirthelms)	IF UNDE		IF UNDER	04.4500		AY 3, 1	995		9:30P M
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œ	The second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of th						R LOCATIO					NTY OF C	DEATH
DIRECTOR	THE JOHNS HOPK	INS HOSP	LTAL			BALT	IMOR	E CI	TY_		N	/A	
Ä	10e. STATE 10b. COUNTY			10c. CIT	r, TOWN	OR LOCAT	ION						10d. INSIDE CITY
	Illinois DeKa	lb		Sa	andw:	-	ZIP CODE						LIMITS?  1 X YES 2 NO
NERA	121 West Third St						6054	48				USA	WHAT COUNTRY?
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [ IF YES, GIVE WI	YES 2 XA			If yes, spe	ENDENT O	n, Mexice	n, Puart	GIN? (Specify Yes to Ricen, etc.)	or No-	14. RAC Blac Spec	E — American Indien, ik, White, atc. """ White
	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION ompleted)		CEDENT'S				-	1	6b. KIND OF BU	SINESS/INI	DUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life.	urna]	e retired.)	during mos	st or workin	o .		Newspa	ner		
	17. FATHER'S NAME (First, Middle, Lest) Alois Reymann									t, Middle, Maiden	-		
8	190. INFORMANT'S NAME (Type/Print)							_		iams			
2	Stephanie Bobrowsky	y (Daugh								imber, City or Tow Olumbia			044
	20a. METHOD OF DISPOSITION 1	ral from State	20b. PLACE A	ND DATE O	F DISPOS	SITION (Na		May	, D/	ATE 20c. LO	CATION -	City or To	
1	21. SIGNATURE OF FUNERAL SERVICE LICE	NŞEE	Metro	cre			D ADDRES	SS OF FAC	1:99	5 Cato	onsvi	TTe.	MD
	Quesus	Degle	9		Le	eroy	8 M	Rus	sel.	l C Wit	zke :	Fune	ral Home MD 21045
	23. PART I. Enter the diseases, or co ahock, or haart fallure. Li IMMEDIATE CAUSE (Final disease or condition	at Dnly Dne caus	e on eech line		Ot antar	tha mod	da of dyl	ng, auct	nan ca	erdiac or respi	ratory an	reat,	Approximate Interval Batween Onset and Daath
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in death) LAST	Diah	or as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of as a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a consecutive of a co	Ar.	ter			asl					~15 yrs. ~63 yrs
	PART II. Other algnificant conditions	contributing,to c	leath but not n	esulting i	n tha ur	derlylng	cause q	iven in	Part I.	24s. WAS AN	AUTOPSY	24b	WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICAL	peripher	al Va	scular		Dise	965				PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
2	DID TOBACCO USE CONTRI	BUTE TO CAL	ISE OF DEAT	TH YE	s П I	VO 🖂	HNC	FDTAIN					1 - YES 2 - NO
Ž.	25. WAS CASE REFERRED TO MEDICAL			E OF DEAT			OITC	LICIAII					
S		HOSPITAL:	ER/Outnationt 3	DO4	OTHER		- C ( Do	aldana.		her (Specily)			
H	27. MANNER OF DEATH	26a. DATE OF II	NJURY	26b. TIME	OF	28c. INJL	IRY AT	sidence		EŞCRIBE HOW II	NJURY OC	CURED	
ВУ Р	1 Natural 5 Pending	(Month, Day	(, Year)	INJ	JRY M	1 Y	RK? ES 2	NO					
	2 Accident Investigation 3 Suicide 6 Could not be determined	28a. PLACE OF building, e	INJURY — At hor tc. (Specify)	me, farm, a	treet, fact	ory, office			261. LC	OCATION (Street a ty or Town, Stete)	and Number	or Rural F	Route Number,
COMPLETED	290. CERTIFIER (Check only and)												
ő	2 MEDICAL EXAMINER:	On the basis of exa	mination end/or in	nvestigation	n, In my o	pinion, de	ath occur	ed at the !	lime, da	ite end place, en	d due to th	ne ceuse(a	n) and menner as stated.
O BE C	291 SIGNATURE AND TITLE OF CERTIFIER MICHAEL SHINSO	~ AH	endin	a P	ry si	cian	29c, LICE	HSE NUM	BER	14	29d, DAT	E SIGNED	(Month, Day, Year)
¥ II	30 NAME AND ADDRESS OF REDSON WHO				-	[	·	L	- '			1 -	

COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print), N. Caroline

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32. REGISTRAR'S SIGNATURE
DAUGLER REVEAL

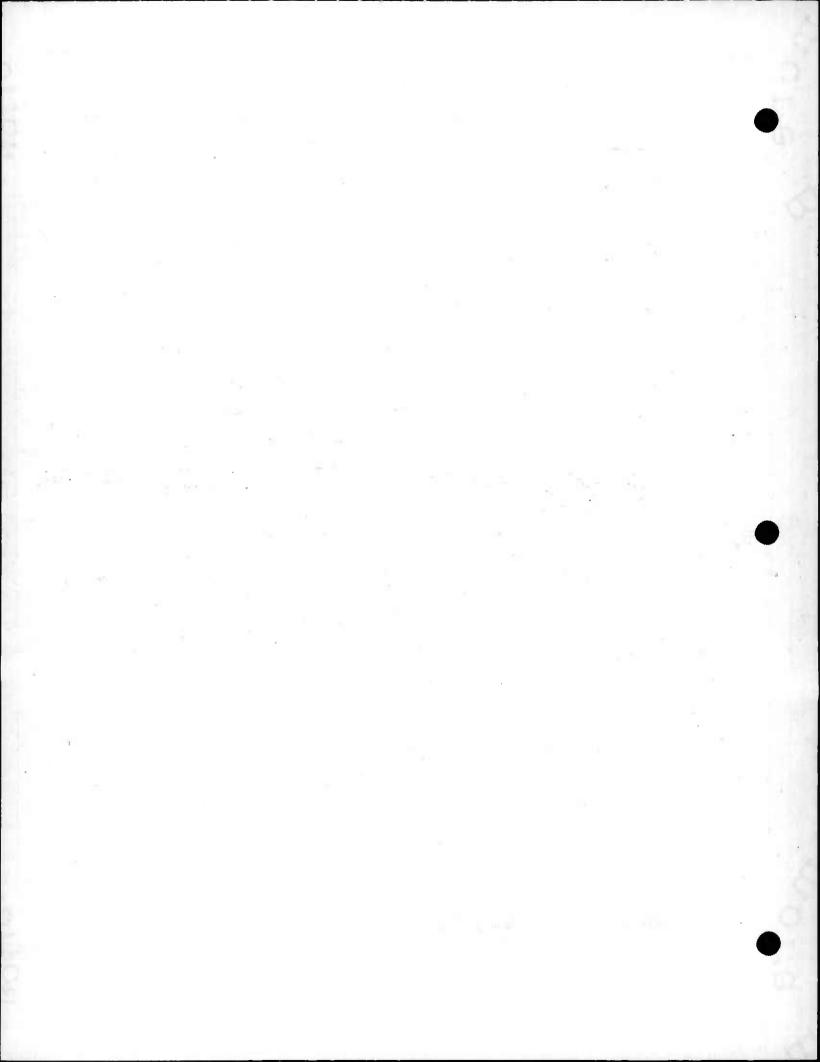
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		1 - FOR STATE REGISTRAR	STATE OF MARYLAN		MENT OF H			YGIENE EG. NO.	
		DECEDENT'S NAME (First, Middle, Last)	Willie Georg				2. DATE OF DI MONTH May 1	EATH	3. TIME OF DEATH 12:15 AM M
pinc		4. SOCIAL SECURITY NUMBER  2 34 ≈ 36 ≈ 8 4 2 1  98. FACILITY NAME (If not institution, give str	1€M 2 🗡 F 93	YRS.	F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BI (Month, Day, DEC.	19, 190 T	BIRTHPLACE (State or Foreign Country) CNNCSSCC
1, 2, 3 should	CTOR	7805 St. Claire			Dund	or location of d	EATH		timore
permit, Pages	DIRECTOR	Maryland 10b. COUNTY	Baltimore	10c. CITY,	TOWN OR LOCA	Dund	lalk		10d. INSIDE CITY LIMITS? 1 YES 2 X NO
ian. -transit	FUNERAL	10. STREET AND NUMBER 7805 St. Claire 11. MARITAL STATUS				f. ZIP CODE	21222	Unit	n of what country? ted States
215-0020 attending physician se as the burial-tra	ВУ	1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U. FORCES? 1 1 YES 2 IF YES, GIVE WAR OR DATE	2 X NO	If yes, sp	CENDENT OF HISPA Hecity Cuban, Mexico 3 2 XNO Specif	en, Puerto Rican,		. RACE — American Indian, Black, White, atc. Specify: White
	COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	CATION 16  Completed)  College (1-4 or 5 +)		ork done during mo retired.)	ON ost of working	18b, KIND	OF BUSINESS/INDUS	
YLAND 21 by the hospital or be detached for u	OMP	8 Years 17. FATHER'S NAME (First, Middle, Last)		Seams	tress	18. MOTHER'S NA		Sewing Melden Surname)	
RYL ned by th	BE C	Edward Yarworth 190. INFORMANT'S NAME (Type/Print)		1		Jane H			
MAR e retained e 5 should notified	2	Mrs. Marauerite	Lowis			nnd Number or Rural N. ROAd		y or Town, State, Zip Co MD 212	
ORE, e 6 may be ector, page must be		20a, METHOD OF DISPOSITION 1 ØL Burlal 2 Cremation 3 Remo	20b. PL	LACE AND DATE OF	DISPOSITION (No		DATE	20c. LOCATION — CIT	y or Town, State
Fige 6 all directo		4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE OAR	Lawn C				Baltimor	e, MV ndalk, Inc.
BALTIN after death. Pag by the honeral of noval. cal examiner		Degan	E. Loed	_	7922	Wise Au	e. Dun	dalk. Mar	yland 21222
760  Within-24 hours after ompletely filled in by the cremation, or removal event, the medical		IMMEDIATE CALICE (EL)	emplications that caused the let only one cause on each CAR D 10	n Ilne.					Approximata interval Between Onset and Daath
68 and cand bunia	NO	Sequentially list conditions,	DUE TO (OR AS A CO	PL L	UNG				
	RTIFICATION	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	CHRONIC DUE TO (OR AS A CO	OBS TRI	UCTIVE	LUN	14 I	DISEASE	
DS, P.O. I the death certific the attending pi d Mental Hygiene Injury, or othe	CERTI	resulting in death) LAST	CHRONIC	BROM	4CHIT	21			
T to A to A	MEDICAL	PART II. Other algorificant conditions LO RO HARY MALKU TRI	ARTERY	not resulting in D1SEA	the underlying	g cause given in		WAS AN AUTOPSY PERFORMED? YES 2 NO	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
> A +		DID TOBACCO USE CONTR		DEATH YES	□ NO □	UNCERTAIL	v 🗆		1 Q YES 2 NO
구 두 원용 등	PHYSICIAN:		HOSPITAL:	PLACE OF DEATH	(Check only one)				
OF VI PHYSICIAN: this certification with the St rked, or It	нүѕ	1 YES 2 NO  27. MANNER OF DEATH	1 Inpatient 2 ER/Outpatie	26b. TIME	OF 28c. INJ			elly) E HOW INJURY OCCUR	EO
	ВУР	1 Patural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUF	M 1 1	PRK? YES 2 NO			
TEN TTEN TTEN TTEN TTEN TTEN TTEN TTEN	ETED	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY — building, etc. (Specify)	At home, farm, atr	eet, factory, offic	•	281, LOCATION City or Town	(Street and Number or n, State)	Rural Route Number,
로 로 로 본	COMPLET	one) 2 MEOICAL EXAMINER	CIAN: To the best of my knowledges: On the basis of examination en						euse(a) and manner as stated.
TO THE HOSPI TO THE FUNER be filed within	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER Source Condend U	0	MD		D271	SE S	29d. DATE S	GNEO (Month, Day, Year)
1		SAVINDER K J		artiel-		Du	ndalli	M)	21222
0		31. MAY 0 4 1995 4	32 PEGISTRAR'S SIGNATU	IRE LL					



funeral director, page 5 should be detached for

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notified

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medical examiner

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

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filled in by the figure, or removal.

Pages 1, 2, 3 should

permit.

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete, filled in by the	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	9R	H	Poe	ě
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FOR STATE REGISTRAR 1 CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH YEAR BARTRATI LEEDER 0745 MIAY 31-1995 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) a. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS 1 X M 2 | F 003-07-6627 76 VRS July 1, Connecticut 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Northwest Hospital Center Randallstown Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Rockdale 1 YES 2 K NO FUNERAL 10e. STREET AND NUMBER 10g, CITIZEN OF WHAT COUNTRY? 8343 Mindale Circle 21244 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yaa or No—
If yea. specify Cuben, Maxican, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES

WW II 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Maxican, Puerto Ri 1 Never Married 2 Married BY 3 Widowed 4 Divorced Specify: White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working 15. DECEOENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Textile Colorist 1 Year Rockland. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Joseph McCarroll Leeper BE Ethel Campbell 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ACCRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Grace Leeper 8343 Mindale Circle Apt. A Baltimore, MD 20a. METHOD OF DISPOSITION
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State ry crematory or other place) Woodlawn Cemetery 4 Donation 5 Other (Specify) 5/4 Woodlawn, Maryland 21. SIGNAPURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Loring Byers Funeral Directors, Inc. has Samo 8728 Liberty Road Randallstown, MD 21133 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata ahock, or heart failure. List only one ceuse on each line. Interval Batween IMMEDIATE CAUSE (Final Onset and Death disease or condition_ ESPIRATORY FAILURE DAY resulting in death) DUE TO (OR AS A CONSEQUENCE OF) OPD YEARS Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate couse. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 TES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF OEATN (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 Inpatient 2 - ER/Outpatient 3 - DOA ng Nome 5 ☐ Rasidenca 8 ☐ Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending NA 1 YES 2 NO 2 Accident Investigation 3 Suicide 28s. PLACE OF INJURY — At home, farm, street, factory, office 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be detarmined 4 Homicide 29a, CERTIFIER 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as atsted. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 14.5. 1.00 . . . . 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 043462 111 1995 MIAY 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATN (ITEM 27) (Type, Print) 54010LD COURT ROAD, BALTIMORE MO 21133 MO 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

AND PROPERTY OF STATE

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIFNE

	REGISTRAR		CERTIF	ICATE C	F DEATH	F	REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)  MICHIAEL	1 \ <	?			2. DATE OF MONTH	DEATH DAY	VEAD	TIME OF OEATH
	4. SOCIAL SECURITY NUMBER 5. SEX	1 405 #		I		INIA.	A 12, 1		20.3
	187-24-6795 NOV	20F 4	yrs. last birthday)	MONTHS DAY	B HOURS MIN.		28,1951	PENNS	YLVANIA
œ	9a. FACILITY NAME (If not institution, give street and nu	umber)		9b. CITY, TOV	N OR LOCATION OF DI		100000 100	NTY OF DEAT	Н
DIRECTOR	SINAI HOSPITAL				BALT	IMORE		V/A	
3	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LO	CATION			10	d. INSIDE CITY
0	MARYLAND BALTI	MORE		BAI	TIMORE			1	LIMITS?
AL	10e. STREET AND NUMBER				101. ZIP CODE		10g. CIT	IZEN OF WHA	T COUNTRY?
Ë	2213-A WOODBOX LANE				21209			USA	
FUNERAL	11. MARITAL STATUS  1 Never Married 2 Married FORC	DECEDENT EVER IN L CES? 1 YES	J.S. ARMED	13. WAS	ECENDENT OF HISPAI specify Cuban, Maxica	NIC ORIGIN? (S	pecify Yes or No-	14. RACE Black, W	American Indian
BY	3 Wildowed 4 Divorced IF YE	S, GIVE WAR OR DATE	EŚ	10	ES 2 XNO Specif	у:	.,,	Specify:	WHITE
	15. DECEOENT'S EDUCATION	1	6a. DECEDENT'S	USUAL OCCUP	TION	165 KIN	ID OF BUSINESS/INC	MIETEV	MITTE
COMPLETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College	(1-4 or 5+)	(Give kind of silfe. Do NOT us	work done during	most of working	loo. rai	D 01 D00111233/1112	7031H1	
릴	4	(140.04)	WAIT	OR WAI	ER	1	RESTAURAN	ידינ	
Š	17. FATHER'S NAME (First, Middle, Last)						e Maiden Surname)		
BE	ARTHUR	LIS			HARR	IET	I	FISCHE	R
6	19a. INFORMANT'S NAME (Type/Print)	7	19b. MAILING	ADDRESS (Str	et and Number or Rural I DBOX LANE	Route Number, (	City or Town, State, Zip	Code)	
-	MR. BRUCE BERESON	V	221.	3-A WOC	DBOX LANE	BALTI	MORE, MD	21209	
	20e METHOD OF DISPOSITION 1 D Buriel 2 Commetted 3 Removal from		LACE AND DATE (		(Name of	DATE	20c. LOCATION —	City or Town,	State
	4 Donation 5 Other (Specify)		BALTIMO	RE HEBF	EW - 5-3-	1995 в	ALTIMORE,	MD	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	10			LEVINSON		e the		
	I todaly to lite	Ilman	,		O REISTER			DT MODE	MD O
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO	ONSEQUENCE OF	F):					
빙	d								
- 11	PART II. Other aignificant conditions contrib	uting to death but	not reauiting	in the underi	ing cause given in	Part I. 24e	. WAS AN AUTOPSY		RE AUTOPSY FIN
EDICAL						15	PERFORMED?	CO	MPLETION OF CA
WE									DEATH?
ž	DID TOBACCO USE CONTRIBUTE	TO CAUSE OF	DEATH YE	S 🗆 NO	UNCERTAIN	VO			
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPE		PLACE OF DEAT		00)				
PHYSICIAN:	1 Tes 1 THO	tient 2 ER/Outpati	ent 3 🗆 DOA	OTHER:	ome 5 🗆 Residence	6 Other (Sp	ecify)		
ВУ РН		DATE OF INJURY (Month, Day, Year)	28b. TIM	URY	NJURY AT WORK? YES 2 NO	28d. DESCRIE	BE HOW INJURY OC	CURED	
	3 Suicide 8 Could not be determined	PLACE OF INJURY — building, atc. (Specify)	Al home, ferm, s	streel, factory, o	fica	28f. LOCATIO City or To	N (Street and Number wn, State)	or Rural Route	Number,
<b>a</b>									
<b>a</b>	29a. CERTIFIER Check only CERTIFYING PHYSICIAN: To the	ne best of my knowled	ge, dasth occurre	ed at the time, o	sta and place, and due	to the cause(a)	and menner as stat	ed.	
									d manner aa sta
COMPLETED	(Check only CENTIFYING PHYSICIAN: To the	basis of examination a	nd/or Investigatio	n, In my opinio		time, data and	place, and due to th	a cause(s) an	
BE COMPLETED	(Check only one) 2 MEDICAL EXAMINER: On the b	basis of examination a		n, In my opinio	, death occured at the	time, data and	place, and due to th	E SIGNED (Mo	of manner as star
BE COMPLETED	(Check only one) 2 MEDICAL EXAMINER: On the b	P G TED CAUSE OF OEATH	nd/or Investigatio	n, In my opinion	29c. LICENSE NUN	time, data and	pieca, and due to th	E SIGNED (Mo	nth, Day, Year)
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

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31. DATE FILEO (Month, Day, Year) MAY 0 4 1995 100 NORTH

32. REGISTRAR'S SIGNATURE

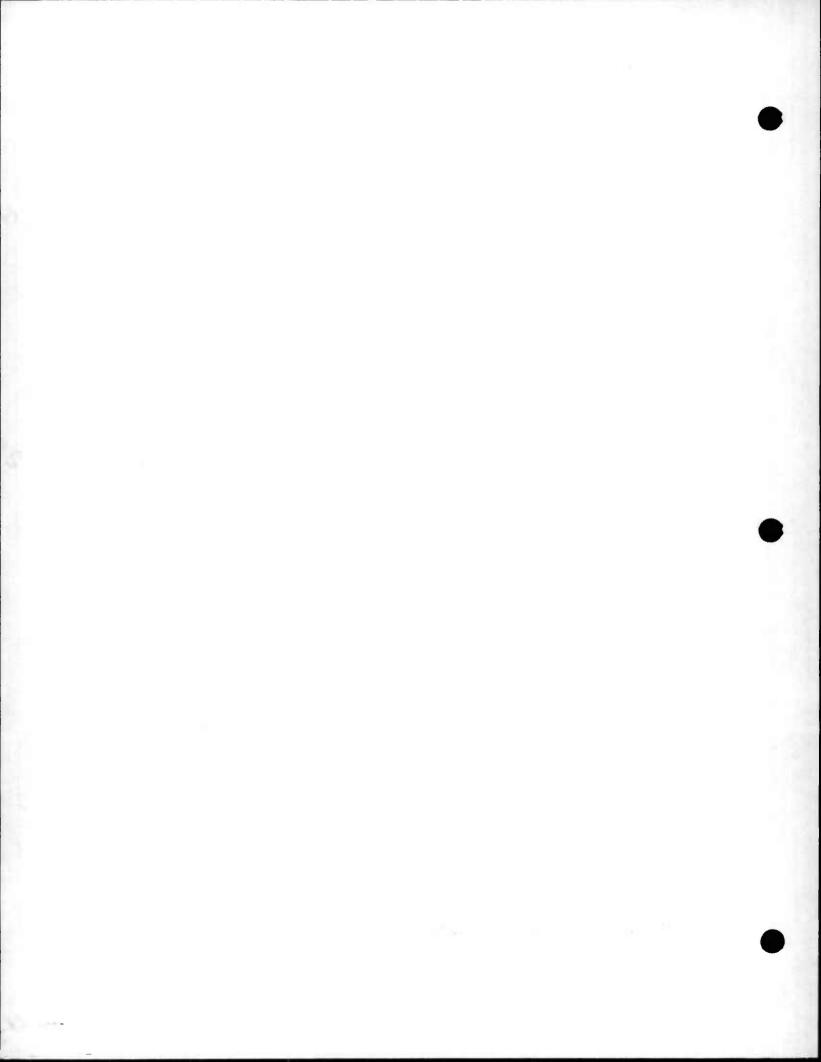
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT. If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1, OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 95 YEAR LAW MARIE MAY 6.15 AM 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Dev. Year)

July 12,1927 Maryland 5. SEX 6. AGE (In yrs. last birthday) JE UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 F DAYS HOURS 216-20-2212 67 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Church Home Hospital Baltimore N / RESIDENCE OF DECEDENT 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Middle River 1 YES MYNO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2217 Graythorn Rd. 21220 U.S.A. 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 K Married If yes, specify Cuban, Maxican, Puarlo Ri 1 YES 2 NO Specify: IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced Specify: White COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16h KIND OF BUSINESS/INDUSTRY mentary/Secondary (0-12) College (1-4 or 5+) Housewife Home 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Schofield George BE Mary Maskell 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Charles E. Law, 2217 Graythorn Rd. Baltimore, MD Jr. 21220 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 1 Burial 2 Cremation 3 Ramoval from State
4 Donation 6 Other (Specify) oak" Lawn Cemetery 5/5/95 Baltimore Co. MD 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY
Bruzdzinski Funeral Home P.A. 1407 Old Eastern Ave. Balt.MD 21221 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart feilure. List only one cause on each line. **IMMEDIATE CAUSE (Final** Onset and Dasth disease or condition_ BILATERAL INEUMONIA resulting in death) FEW DAYS DUE TO (OR AS A CONSEQUENCE OF): ASPIRATION CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY PINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? DIABETES MELLITUS 1 YES 2 NO 1 - YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 🗷 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 Dit Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Realdence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending investigation 1 YES 2 NO BY 2 Accident 3 Sulcide 26a. PLACE OF INJURY — Al homa, larm, street, factory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29a. CERTIFIER 1 📈 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) D-40521 ►MAY, 3,1995 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) BROADWAY BALTIMORE, MD 21231



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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Union

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rundare be executed within the hours are death. Page 6 may be retained by the hospital of	ctor, page 5 should be de		nust be notified at once.
nours after death. Page	ed in by the funeral direc	, or removal.	MPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notifii
to be executed within the	sician and completely fill	prior to burial, cremation	traumatic event, the
utal the death certificat	ed by the attending phy	h with the State Dept. of Health and Mental Hygiene prior to burial	any injury, or other
PHISHORAN: THE TAN TEQUITES UT	certificate has been sign	the State Oept. of Heal	, or item 23 shows
JINE HUSPITAL UN ALTENDING PRITE	: Afte	be filed within 72 hours after death with	It Item 28 is marked
ILL INC HUSTIL	TO THE FUNERAL DIRECTOR	be filed within 7	IMPORTANT: 1

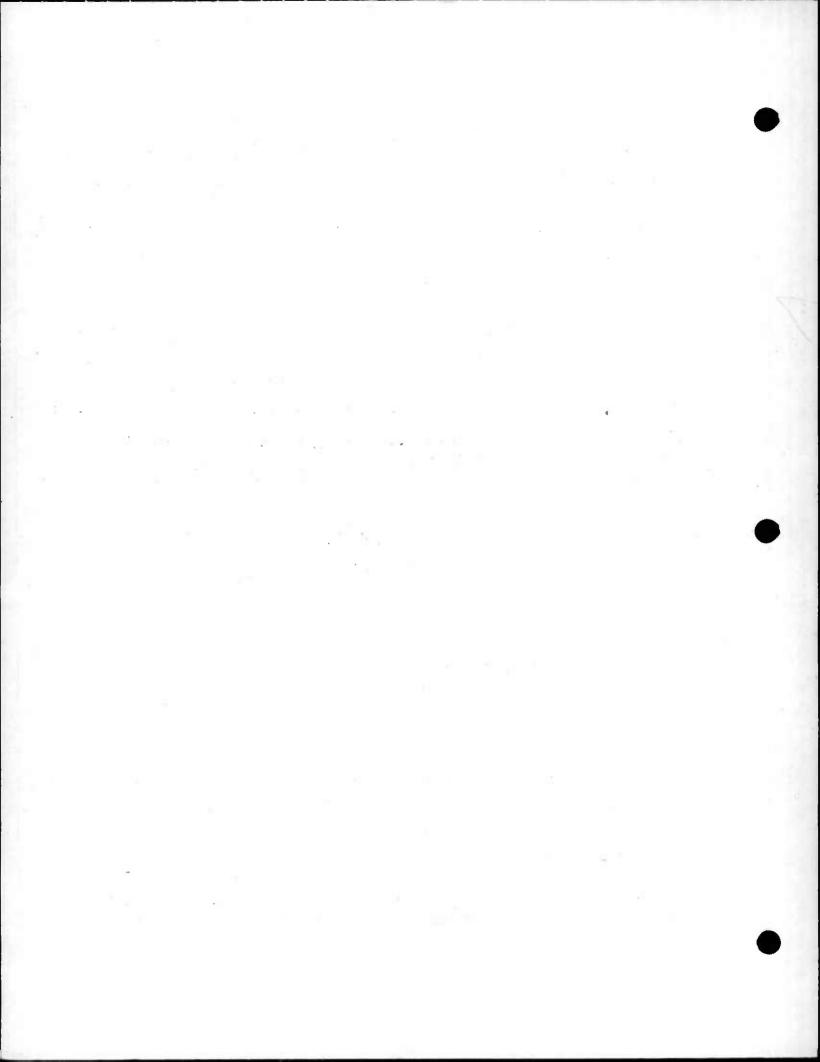
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Genevieve Marciszewski 1995 May 9:45 Dw 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign Country) 215-07-1758 1 M 2 X F DAYS HOURS 76 April 17,1919 Mary land 9a. FACILITY NAME (If not institution, give street and number) 9h. CITY, TOWN OR LOCATION OF DEATH 4530 Shamrock Avenue Baltimore N/A RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland N/A Baltimore 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 4530 Shamrock Avenue 21206 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puerto Rican, atc.)

1 □ YES 2 X NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married IF YES, GIVE WAR OR DATES 3 Widowed 4 Divorced White 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 8 Homemaker N/A 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Stanley Rostek Apolonia Kaminski 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Melvin M. Marciszewski 4530 Shamrock Avenue Baltimore, Md. 21206 20a. METHOD OF DISPOSITION

1 X Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Holy Rosary Cemetery 4 Donation 6 Other (Specify) 5/6/95 Baltimore, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T. Zavovna 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. male T. 5305 Harford Road Baltimore, Md. 21214 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate ahock, or heart fellure. List only one cause on each line. Interval Between **IMMEDIATE CAUSE (Final** Onset and Death disease or condition lutiple organ systems failure resulting in death) week Petastatio breast cancer 2 upara Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF)if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): PART II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS Servero AWAILABLE PRIDR TO COMPLETION OF CAUSE OF DEATH? protein energy malnutration PERFORMED? 1 TES 2 NO Demonter 1 - YES 2 - NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 M Rasidence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28s. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO 2 Accident 3 Suicide 28s. PLACE OF INJURY — At home, farm, atreet, tectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. CERTIFIER 1 M CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Boston D28462 195 /3

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Johnson Professional

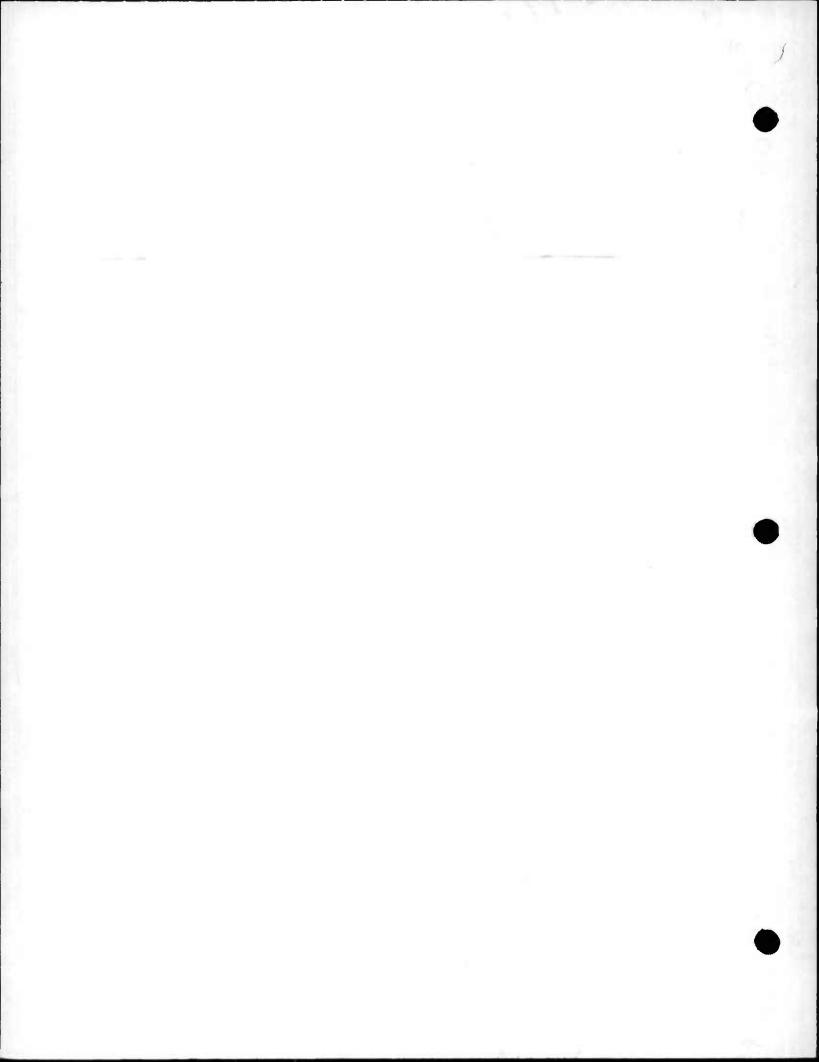


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	4 Donation 5 Dulaney Valley Mem. GardensMAY Timonium, MD  21. SIGNATURE OF FUNETAL SHIVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
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SIGNED (1)  4/30	WERE AUTOPSY FI AMAILABLE PRIOR  OF DEATH?  VXYES 2 1	etween d Daath LYS //S INDINGS TO CAUSE NO

MAY 04 1995 January Cons

Item10e,g,Film723,5/4/95,1t
FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH 1. OECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY YEAR DAVID JR. 1995 MADDEN APRIL 30. 6:55A 4. SOCIAL SECURITY NUMBER 5. SEX NOV Description 1959 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 218-76-4246 35 DAYS tX XM 2 □ F MD Sa. FACILITY NAME (If not institution, give street and number) Bb. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR Pages 1, 2, 3 THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTO BALTO YES 2 NO permit. I FUNERAL 10s. STREET AND NUMBER AUGUSTA AVE 10f. ZIP COOF 10g. CITIZEN OF WHAT COUNTRY? 1239 ACUSTA AVE funeral director, page 5 should be detached for use as the burial-transit 21229 U.S.S USA the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: FORCES? 1 YES 2 NO 1X XNever Married 2 Married Specify: BLACK BY 3 Widowed 4 Divorced 16a. OECEOENT'S USUAL OCCUPATION COMPLETED 15. OECEOENT'S EOUCATION (Specify only highest grade completed) 16b. KINO OF BUSINESS/INOUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) TRUCK DRIVER BALTO CITY 1174 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) MADDEN DAVID H SR ANN SMITH hours after death. Page 6 may be retained by BE notified 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 ANN SMITH MADDEN J.239 N AUGUSTA AVE BALTO, MD 21229 pe 20a. METHOO OF OISPOSITION
1X Burial 2 Cremation 3 Removal from State 20b. PLACE AND OATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, Stata must LOUDON PARK 4 Donation 5 Other (Specify) 5595 BALTO, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LIGENSEE 22. NAME AND ADDRESS OF FACILITY 10mpsm Je MARCH F/H-WEST 4300 WABASH AVE Vne filled in by the fillion, or removal. medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory strest, shock, or heart feliure. List only one cause on each line. Approximete 8 Interval Between IMMEDIATE LAUSE (Final and completely filled to burial, cremation, o Onset and Death the disease or condition resulting in death) PSENDOMONA PNEUMONIA OUE TO (OR AS A CONSEQUENCE OF): 12days event, DIVISION OF VITAL RECORDS, P.O. BOX 68769 traumatic CETROVIPAL NEECTION CERTIFICATION Sequentially list conditions, QUE TO (OR AS A CONSEQUENCE OF) prior to If any, leading to immediate cause. Enter UNDERLYING physician requires that the death certificate be CAUSE (Disease or Injury that initiated events resulting in death) LAST by the attending phrand Mental Hygiene OUE TO (OR AS A CONSEQUENCE OF): Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying ceues given in Part i. 24s. WAS AN AUTOPSY PERFORMEO? MEDICAL 24b. WERE AUTOPSY FINGINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? shows any Signed Health a 1 TES ZX NO 1 | YES 2 | NO Jo. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ PHYSICIAN: has be Dept. OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) item EXAMINER? certificate I HOSPITAL: OTHER: Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 6 the 27. MANNER OF DEATH 26a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26d. OESCRIBE HOW INJURY OCCURED marked, this 1 Netural 2 Accident 5 Pending Investigation 1 YES 2 NO BY After 1 3 Suicide DIRECTOR: Aff hours after de-item 28 fs n 26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, COMPLETED 6 Could not be 4 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTE DE filed within 72 hours at IMPORTANT: If item 21 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.
2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the (Check only one) MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) M1045 4/30/95 2 30. NAME AND ADDRESS OF PRESON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. HUNTER BALTIMORE, MD MD JOHNS HOPKINS HOSPITAL WILLIAM 31. OATE FILED (Month, Day, 32. REGISTRAR'S SIGNATURE Pr 1.70 1995 MAY 04



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	1. DECEOENT'S NAME (First, Middle, Last)		CERTIFICATE OF		REG. NO.		3. TIME OF DEATN
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	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (	(In yrs. last birthday) IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH	a   C	HRTNPLACE (State or Foreign
	9a. FACILITY NAME (If not institution, give :		YRS. 9b. CITY, IOWN	OR LOCATION OF DEAT		923	D. C.
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DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNT	Υ	10c. CITY, TOWN OR LOCA	ATION			10d. INSIDE CITY
	ma t	toward	Colum	mbla			1 YES 2 NO
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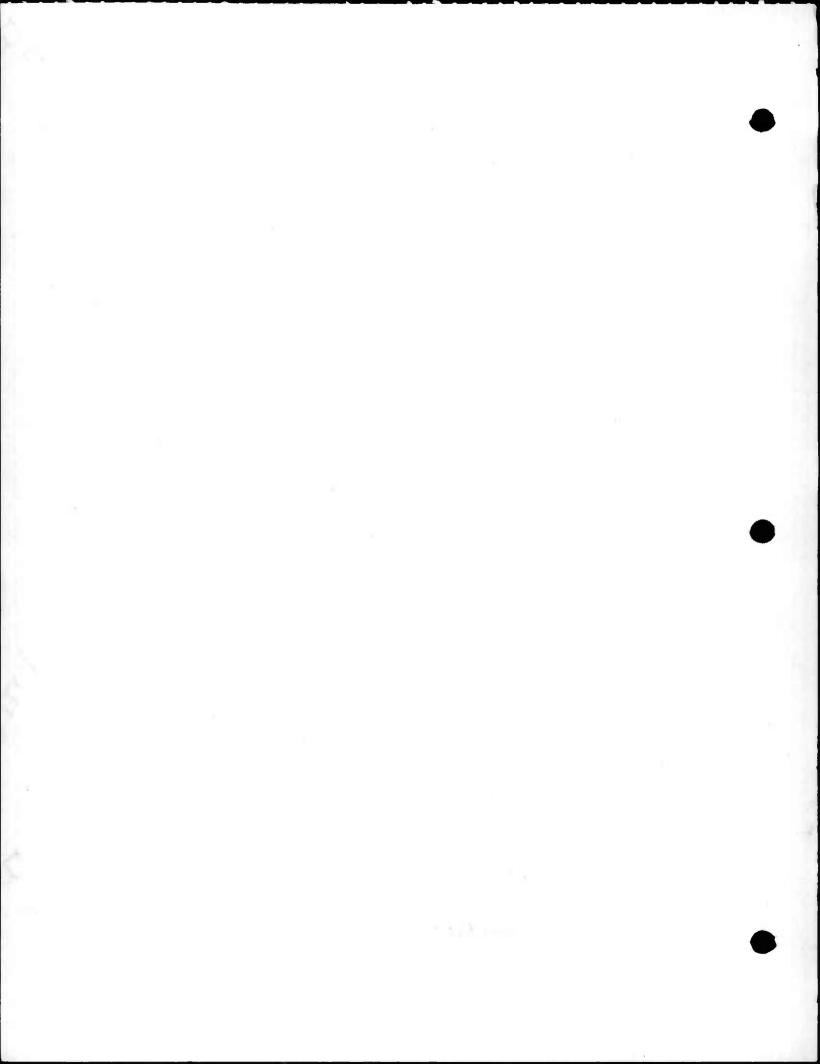
BALTIMORE, MARYLAND 21215-0020 four after death. Page 6 may be retained by the hospital or attending physician. In by the funeral director, page 5 should be detached for use as the bunia-transi TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withling TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely and Mental Hydiene prior to burial, cremat

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Health and Mental Hygiene prior to buria ows any Injury, or other traumatic	CERTIFICATION	Sequentially list conditi		DUE TO	(OR AS A	CONSEO	UENCE O	F):								
prior	2	cause. Enter UNDERLYI CAUSE (Disease or inju	NG													
othe	E	that initieted events resulting in deeth) LAS	·	DUE TO	(OR AS A	CONSEO	UENCE O	F):								
y, or	EH EH						_									
Injur		PART il. Other algnifice	nt condition	contributing to	deeth b	but not resulting in the underlying cause given in Pert							WERE AUTOPSY FINDINGS			
alth ar	MEDICAL											_   .	YES 2	A		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
of He	_							10.00					•			1 Tes 2 No
Dept. of	ÿ	DID TOBACCO U		IBUTE TO CA					NO [		ERTAIN	۷ 🔲 L				
State Dept.	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:		26. PLACE	1	OTHE		9)						
e g	PHYS	1 YES 2 NO		1 inpetient 2 =		patient 3		4 🗆 Nu	ursing Ho		sidenca	8 Other (S				
S WELL		1 Natural 5	Pending	(Month, De		l	28b. TIM INJ	URY	W	IJURY AT ORK? YES 2	No	26d. DEŞCR	IBE HOW IN	NJURY OC	CURED	
0	D BY	2 Gudelde	Investigation Could not be	28s. PLACE O	F INJURY	— At hor	ne, term, a	street, to				261. LOCATIO	ON (Street a	nd Number	or Aural A	Oute Number
hours after Item 28 I	ETE	4 Homicide	detarmined	building,	atc. (Spec	erfy)						City or 1	own, Stafe)			
N 900	COMPL			IAN: To the beat of												and manner as stated.
PHTA	BE C	296. SIGNATURE AND TITLE	OF CENTIFIER	1/ /	/					29c. LICE	NSE NUN	BER		29d, DAT	E SIGNED	(Month, Day, Year)
be filed within 7	면 일	30. HAME AND ADDRESS OF	1 1	wy	E 05 25	ATU ATE	970 /T	D-2		103	26	79		<b>&gt;</b> 3	5/3/	93
-		TIMOTHY	HER		MS.	)	62	12	40	ork	21	B	Him	hors.	M	1) 21212
		MAY 0 4 199	5 Jal	2. REGISTRA	R'SIGN	ATURE			-		)					,
				1												





ITEMS: 23 PART I, II, 27, PER MEO FILM g-724 6/5/95 t.t

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 55 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

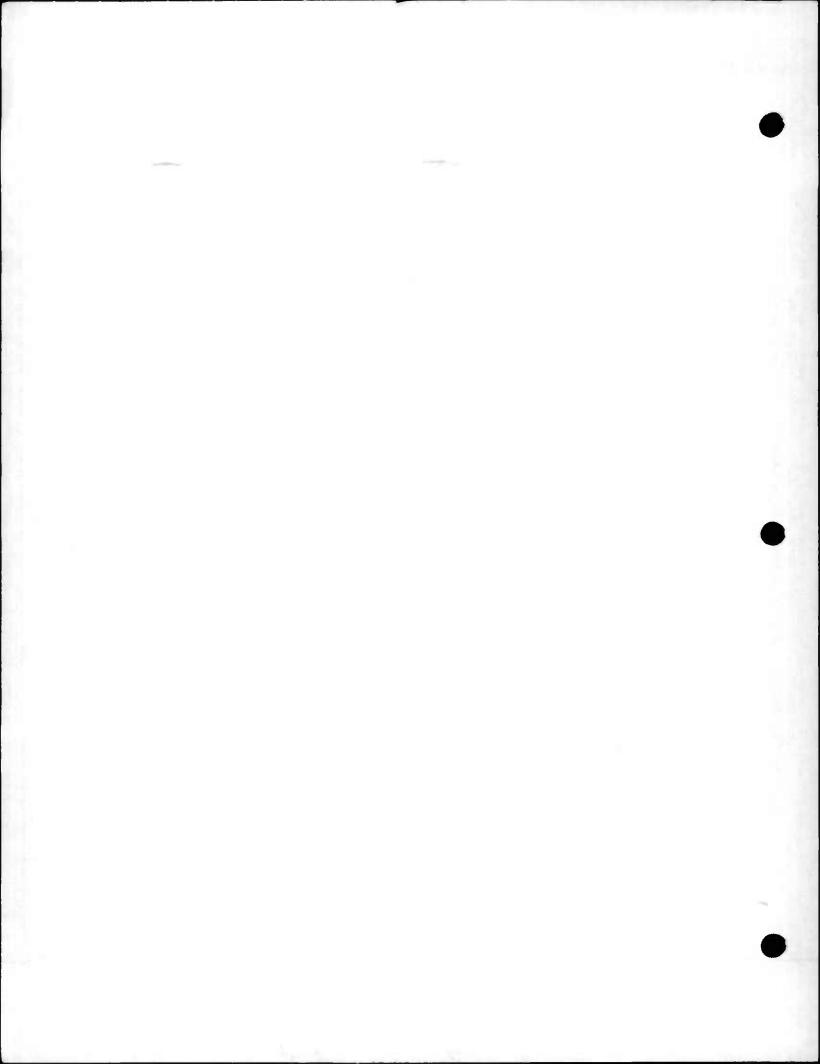
X

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGICAG

	1 - STATE REGISTRAR	CERTIF	ICATE OF	DEATH	REG.				
	1. DECEDENT'S NAME (First, Middle, Lest)				2. DATE OF DEAT	(		3. TIME OF DEATH	
	Doris Katherine		Noona	n	April 30 1995			2216 M	
		E (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF BURTH		8. BIRTH	PLACE (State or Foreign	
	71	46 YRS.	MONTHS DAYS	HOURS MIN.	July 8,	1948	New	York	
_	9a. FACILITY NAME (If not institution, give street and number)  9b. CITY, TOWN OR LOCATION OF DEATH  9c. COUNTY OF DEATH								
DIRECTOR	University Hospital Baltimore N/A								
W	10e. STATE 10b. COUNTY	10c. CIT	Y, TOWN OR LOCAT					10d. INSIDE CITY	
	Maryland N/A			Baltimo	re			1 YES 2 NO	
FUNERAL	847 W. Lombard Street		10f.	21201		10g. CF	USA	HAT COUNTRY?	
15	11. MARITAL STATUS 1 Never Married 2 Married 12. WAS DECEDENT EVER FORCES? 1 YE	IN U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	IC ORIGIN? (Specity	Yes or No-	14. RACE	— American Indian, , White, etc.	
B	1 TES 2 NO Specify:							White	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Give kind of v	USUAL OCCUPATIO	N st of working	16b. KIND OF	BUSINESS/IN			
in in	Elementary/Secondary (0-12) College (1-4 or 5+)  12th  Housekeeper  Hotel								
N N	Housekeeper Hotel								
H	SO INFORMANT'S NAME (Top Class)								
2	Ronald L. Gorden	n B <b>l</b> vd. I				)			
	20e. METHOD OF DISPOSITION 1 Burles 2 Gremetion 3 Removal from State 4 Donation 5 Other (Specify)  20b. PLACE AND DATE OF DISPOSITION (Name of Manual from State Method of Cremetory of other place).  20b. PLACE AND DATE OF DISPOSITION (Name of Manual from State Method of Cremetory of other place).  20c. LOCATION — City of Town, S Baltimore, MD							en State	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE DAWN F. McDonald 22. NAME AND ADDRESS OF FACILITY								
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE DAWN F. McDonald    Common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of the common of								
	23. PART I. Enter the diseases, or complications that caus shock, or heart feliure. List only one cause on	ed the death. Do n	ot enter the mod	de of dying, such	ea cerdiec or re	spiretory as	rest,	Approximate	
	IMMEDIATE CAUSE (Final	each line.						interval Between Onset and Death	
	disease or condition ARTERIOSCLER	OTIC CARDIO	VASCULAR D	ISEASE					
	DUE TO (OR AS	A CONSEQUENCE OF	):						
ON O	Sequentially list conditions, b. DUE TO (OR AS	A CONSEQUENCE OF	3.						
N.	cause. Enter UNDERLYING		,					j	
CERTIFICATION	that withhelp desires	A CONSEQUENCE OF	):						
E	resulting in deeth) LAST								
	PART II. Other algnificent conditions contributing to deeth	but not resulting i	n the underlying	ceues abuse in I	Boot I Dec 1990	AN AUTOPSY	Lau		
DICAL	ASTHMA		. the andertying	coose given in r	PER	ORMED?		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE	
MED					1 YES	2 🗌 NO		OF DEATH?	
≥	DID TOBACCO USE CONTRIBUTE TO CAUSE	OF DEATH VE	SINOI	LINICEDTAIN				1 TYES 2 NO	
AN	25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF DEAT		DIACEKIAIN					
PHYSICIAN:	EXAMINER?  1 XYES 2 NO  1 Inpatient 2X ER/Ou		OTHER:	5 Residence 8	Other (Specific)				
Ě	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year)	28b. TIM	OF 28c. INJU	JRY AT	284. DESCRIBE HO	W INJURY OC	CURED		
BY	1)(X) Natural 5 Pending Investigation	INJ	4.4	ES 2 NO					
	3 Suicide 6 Could not be 28e. PLACE OF INJUR	IY — At home, farm, s	treel, lactory, office		28f. LOCATION (Str. City or Town, St	et and Numbe	r or Rurai Ro	oute Number,	
1	4 Homicide determined				Only or nown, or	no)			
COMPLETED	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my kno	wledge, death occurre	d at the time, date	end place, end due t	to the ceuse(s) end	manner es ata	ited.		
O S	one) 2 X MEDICAL EXAMINER: On the basis of exeminate	on end/or investigation	a, in my opinion, de	ath occured at the t	lme, date end place	end due to ti	he ceuse(s)	end menner es stated.	
ш	29b. SIGNATURE AND THE OF CERTIFIER			29c. LICENSE NUM	BER	29d. DAT	E SIGNED	(Month, Day, Year)	
TO B	Theodor M. Ling -	no		0.C.	M.E.	Ma	av 01	1 1995	
1	36. NAME AND ADDRESS OF PERSON WHO COMPLETED ONUSE OF D	EATH (ITEM 27) (Type,	Print)						
	31. DATE FILED (MONTH, DBY, YOR) / 32 REGISTRAT'S DAG	111_P	enn Sti	ceet. B	altimor	e. Ma	aryla	and 21201	
	MAY 0 4 1995 July drugter to	Wall							

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DIVISION	

	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTME	NT OF HEALTH AND TE OF DEATH	MENTAL HYGIE!					
	1. DECEDENT'S NAME (First, Middles, Last) Anthony	Nargi			2. DATE OF DEATH	DAY OY	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER 127-46-1553	1 SECURITY NUMBER  5. SEX  6. AGE (In yrs. last birthday)  F UNDER 1 YEAR  F UNDER 24 HRS.  7. DATE OF BIR  (Month, Days  O 7 - 2								
	9a. FACILITY NAME (If not institution, give s	treet and number)	9b. C	ITY, TOWN OR LOCATION OF		9c. COUNTY	NEW YORK			
DIRECTOR	Maryland Correctional Institution Magarstown Washi									
1 2	10a. STATE 10b. COUNTY	1	10c. CITY, TOW	N OR LOCATION			10d. INSIDE CITY			
	NEW YORK	NEW YORK N/A BRONX								
FUNERAL	100. STREET AND NUMBER	No. STREET AND NUMBER 101. ZIP CODE 10g. CITIZE								
Į Ę	1720 MAYFLOWER	AVENUE  12. WAS DECEDENT EVER IN U.	S ADMED I	1046 3. WAS DECENDENT OF HISP			S.A.			
₩	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 TYPES 2 IF YES, GIVE WAR OR DATE: VIET NAM 1974	2 □NO S	If yes, specify Cuban, Mexic 1 YES 2 NO Spec	can, Puerto Rican, etc.)	s or No 14	RACE — American Indian, Black, White, atc. Specify: White			
ETED	15. DECEDENT'S EDU- (Specify only highest grade		ia. DECEDENT'S USUAL	ne during most of working	16b. KIND OF BU	ISINESS/INDUS	TRY			
1 2	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT use retire.  LABOR		CON	STRUCT	ION			
ONCE.	17. FATHER'S NAME (First, Middle, Last)		LABON		AME (First, Middle, Maide		LON			
	ARMANDO JOH	N NARGI		GLADY		,				
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDR	ESS (Street and Number or Rura			rde)			
9	GLADYS NARGI			FLOWER AVENU						
Tage .	1 Buriet 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State cemeter	ACE AND DATE OF DISP	ce)	1		y or Town, State			
Je.	21. SIGNATURE OF NUMERAL SERVICE LIC	ENSEE	VERTON NA	22. NAME AND ADDRESS OF F	4. 1995 CA	VERTON	NEW YORK			
examiner must be notified at once.  TO BE COM	· Hulles	Start		STERLING ASH 736 EDMONDSO	TON FUNERAL	L HOME,	INC. E. MD. 21228			
ry, or other traumatic event, the medical	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on aach line.  IMMEDIATE CAUSE (Final disease or condition) resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  List only one cause on aach line.  Approximation interval Be Onset and Sharp Consequence of):  Approximation interval Be Onset and Sharp Consequence of):  Approximation interval Be Onset and Sharp Consequence of):  A Phic Sharp Chest Pheumonia Total Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest Pheumonia Sharp Chest P									
MEDICAL	PART II. Other significant condition	s contributing to death but a			Part I. 24s. WAS AF	AN AUTOPSY FORMED?  24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMBINETION OF CAUSE				
or item 23 s YSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	ОТН	26. PLACE OF DEATH (C	heck only one)					
o   ≥	1 VES 2 NO 27. MANNER OF DEATH	1 Pinpatient 2 ER/Outpatie		lursing Home 5 Residence	8 Other (Specify)  28d. DESCRIBE HOW	IN ILIEN OCCUR	NED.			
marked, BY PH	1 Netural 5 Pending	(Month, Day, Year)	INJURY	WORK?	ISS. DESCRIBE NOW	mooni occor	ieu			
28 is TED	3 Suicide 6 Could not be determined	2 Accident  3 Suicide 6 Could not be building, atc. (Specify)  28e. PLACE OF INJURY — At home, farm, street, factory, office  28f. LOCATION (Street and Number or Rural Route Number, Specify)								
COMPLE		CIAN: To the best of my knowledg					ause(a) and menner as stated.			
TO BE COMPLE	296. SIGNATURE AND TITLE OF CERTIFIEF  Tima T-	elele, MD		29c. LICENSE NO.	895		IGNED (Month, Day, Year)			
F	30. NAME AND ADDRESS OF PERSON WHI	204 Phelps	Nd #20							
	MAY 0 4 1995	32. REGISTRAR'S SIGNATU	Randall			1				



020	physicia
<b>BALTIMORE, MARYLAND 21215-0020</b>	cate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicial
10 21	spital or
LAN	y the ho
MARY	retained b
Ë,	ay be
MOM	аде 6 т
ALTI	death. P
m	after
	hours
ō	rithin 24
BOX 68760	ecuted w
X	be a
ĕ	cate

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certific

DIVISION OF VITAL RECORDS, P.O.

										95		338	
	FOR 1 - STATE	STATE OF M							ENTAL HYGIEN	E			
	REGISTRAR		CI	ERTIF	CATI	E OF	DEAT		REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)	LIA	MAR	11	1/	OL	1		2. DATE OF DEATH	W 10	SEAR 3.	TIME OF DEA	ТН
		T	6. AGE (In yrs. les		IF UNDER		IF UNDER 24	A HRS	7. DATE OF BIRTH	17	7.0	CE (State or F	рм
	216-34-1882	1 M 2 F	94	YRS.	MONTHS	DAYS		MIN.	(Month, Day, Year) March 22	1901	Country)		orangri
	9e. FACILITY NAME (If not institution, give stre	set end number)			96. CITY	r, TOWN C	R LOCATION	N OF DEA			TTY OF DEAT		
OR							ore			_	RIA	1	
DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY	1		10c CIT	/ TOWN /	OR LOCAT	ION				100	d. INSIDE CIT	
DIR	Md	HA				imor					1	LIMITS?	
	10e. STREET AND NUMBER	, , , , , ,				101.	ZIP CODE			10g. CITI	ZEN OF WHA		NO
FUNERAL	234 S. Monastery	Avenue					21229	9		1	USA		
P.		12. WAS DECEOENT	EVER IN U.S. AR	MEO	13.	WAS DEC	ENGENT OF	HISPANIC	ORIGIN? (Specify Yes Puerto Rican, etc.)	or No—	14. RACE	American Ind	llen,
BY	1 Never Married 2 Merried 3 🔀 Widowed 4 Divorced	IF YES, GIVE W					2 ☑ NO		Posito Hican, etc.)		Specify:		
	15. DECEDENT'S EDUCA	ATION	16a; DE	CEDENT'S	USUAL O	CCUPATIO	N N		16b. KIND OF BUS	SINESS/IND		nite	
ETI	(Specify only highest grade of Elementary/Secondary (0-12)	ompleted) College (1-4 or 5+)	(G	ive kind of v Do NOT us	vork done e retired.)	during mo:	st of working		TOD. KIND OF BO	3111C33/111D	OSINT		
MP	10			Sec	reta	ry			Natio	ons Ba	ank		
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)								E (First, Middle, Malden	Sumame)			
BE									Lynch				
2									ute Number, City or Tow				
	Joseph Noll, Sr.		20b. PLACE			_	_	Balt	imore, Mo			1000	
	1 Remov	ral from State	cemetery cre	matory or of	her nlecal				5/6 Bal		City or Town,		
	21, SIGNATURE OF FUNERAL SERVICE LICE	NSEE ,	T NEW C	alle	22.	NAME AN	D ADDRESS	OF FACI	LITY				
	+ Haller X	tailes					_		on Funeral			01000	
	23. PART I. Enter the diseases, or co	mplicatione that	caused the de	eth. Do n	ot enter	the mod	de of dylne	a. such	Avenue, I	ratory arr	oet.	21228	
	anock, or haart failure. Li	ist only one caus	e on aech line									interval B Onset an	Between
	disease or condition resulting in death)	Cerel	nous	cula	N	v dislose reumonio A foilue						7 100	ANG.
		DUE TO (	OR AS A CONSEC	DUENCE OF	7:							13	
No.	Sequentielly liet conditions, b.	3020	retion	p	reu	Moi	lia .	-				200	relis
ATI	If any, leading to immediate cause. Enter UNDERLYING	000 300	A CONSEC	JUENCE OF	): 	6	: Î a					35.	O Do A
FI	CAUSE (Disease or injury that initiated events	DUE TO (	OR AS A CONSEC	DUENCE OF	):	Ja	~ une					1	Cevs
CERTIFICATION	resulting in death) LAST	lyper	tensio	4								>54	rous
	PART ii. Other algnificent conditione	contributing to	leath but not r	neultino i	n the un	deriving	cause alv	un in B	ert I. 24s. WAS AN	Atmoney	an un		
CA	hyperporothyro.	B	SSS	A	F	yiing	, couse giv		PERFOR	MED?	AWA	RE AUTOPSY F ILABLE PRIOR MPLETION OF	TO
		astesand	histic	(					1 YES 2	<b>™</b> NO	OF	OEATH?	/
2	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN							NO					
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL			E OF DEAT	H (Check	only one)							
YSI		HOSPITAL:	ER/Outpatient 3	□ DOA	4 Nun		5 🗆 Resid	dence 6	Other (Specify)				
	27. MANNER OF DEATH  1 Natural 5 Pending	28e. DATE OF II (Month, Day		28b. TIME INJ	OF JRY	28c. INJU		2	88d. DESCRIBE HOW I	NJURY OCC	URED		
BY	2 Accident Investigation	200 PLACE OF	IN HIEW ALL		М		ES 2 🗌	-					
8	3 Suicide 8 Could not be determined	building, e	INJURY At hortc. (Specify)	me, rarm, s	treet, ract	огу, опіса		1,	R81. LOCATION (Street e City or Town, Stete)	ind Number	or Rurel Route	Number,	
COMPLET	290. CERTIFIER (Check only	AN: To the best of a	ny knowledne de	ath occurre	d at the "	Ima data	and alone	and altern for	the several and				
¥	(Check only								the ceuse(s) and man ne, date end place, an			d manner ea s	stated.
	MODICAL EXAMINEN.												
	29b. SIGNATURE AND TITLE OF CERTIFIER					1	29c. LICENS						
TO BE CO		D.			-			SE NUMB		29d. DATE	SIGNED (Mo	nth, Day, Year)	

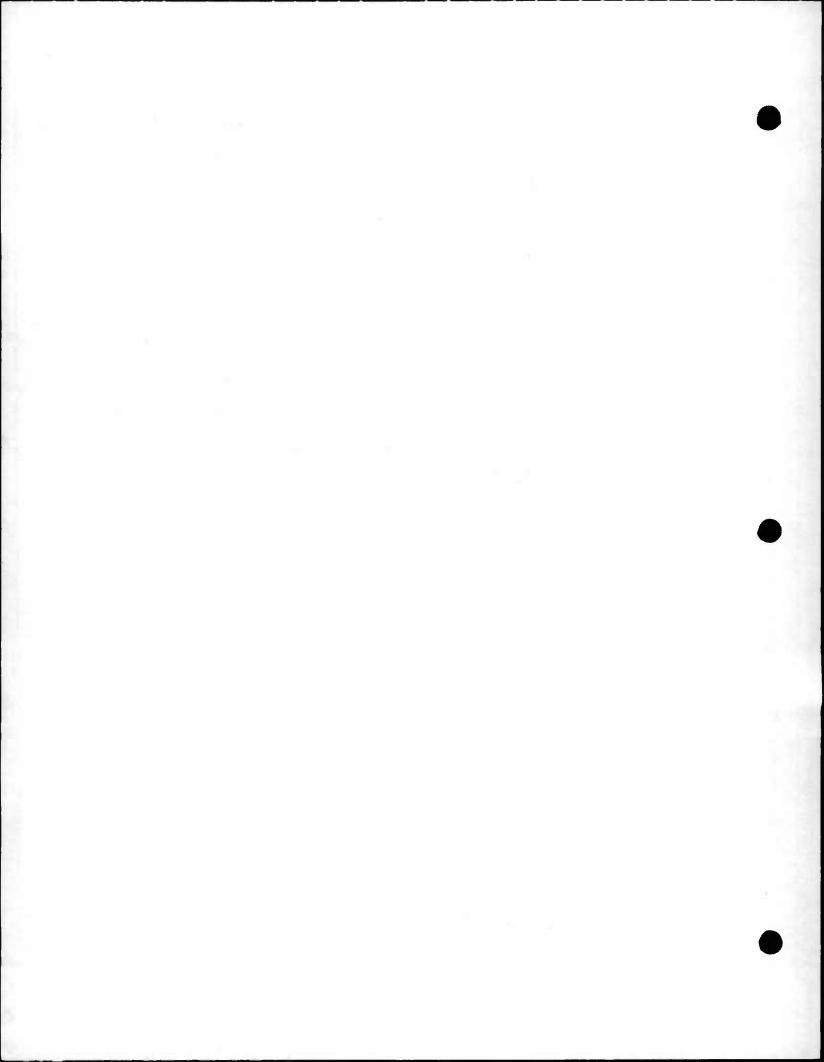
RESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

02 900 CATON AVE, BALTIMORE , 21229

KASZUBA KOBERT STACNES HOSPITAL

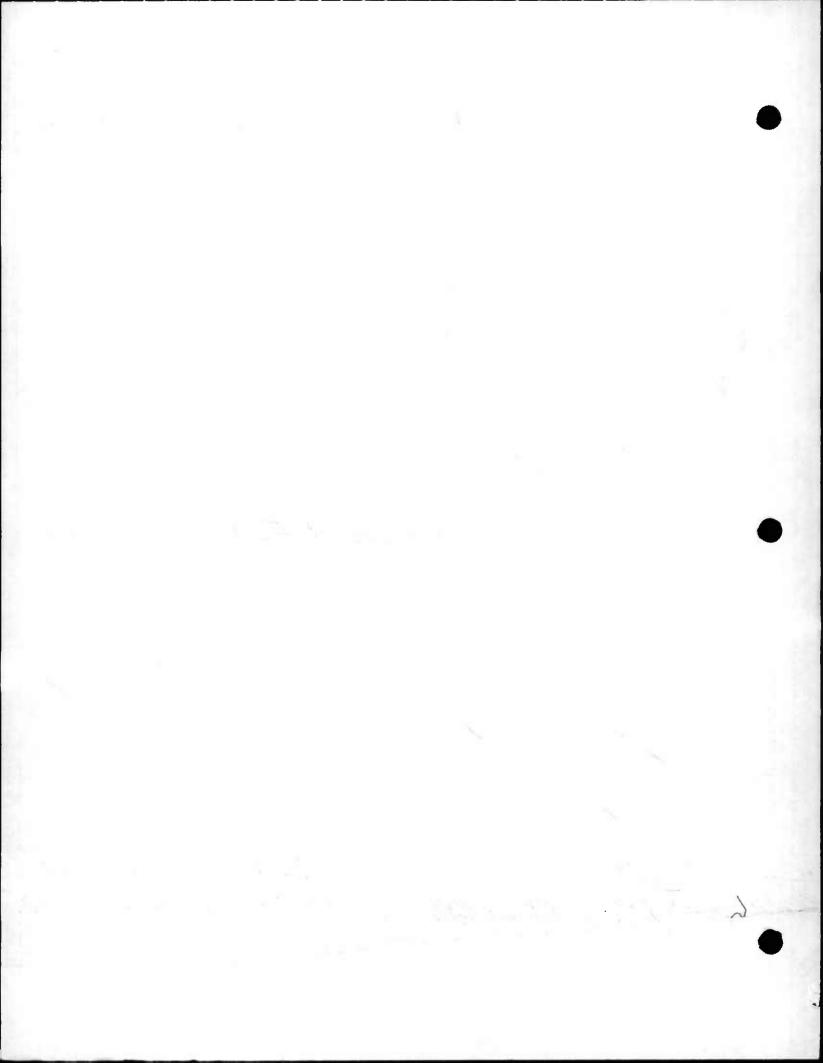
31. DATE FILED (MARIT 1995)

July 188



		FOR STATE REGISTRAR	STATE OF MARY		PARTMENT (			TAL HYGIEN			
		1. DECEDENT'S NAME (First, Middle	s, Last)					ATE OF DEATH		3. TIME OF OEATH	
		Betty S.	Oberle					pril 3	Õ. 199	6:30 p	
		4. SOCIAL SECURITY NUMBER 214 38 2748	5. SEX 8. AGE	(In yrs. lest birt		YEAR IF UNDER	24 400 7.0	ATE OF BIRTH forth, Day, Year) C.18,19		BIRTHPLACE (State or Foreign Country)	
pinous		Se. FACILITY NAME (If not institution	n, give street and number)		9b. CITY, T	OWN OR LOCATI		0.10,15	9c. COUNTY		
1, 2, 3 s	DIRECTOR	3215 Miller Av		Middle River Baltimon							
Pages 1	) H		COUNTY	10	C. CITY, TOWN OR	LOCATION				10d. INSIDE CITY	
permit. Pa		Maryland Ba	ltimore		Mid	dle Riv				LIMITS? 1 ☐ YES 2 🔀 NO	
	RAL	3215 Miller Av	^				_		10	OF WHAT COUNTRY?	
020 physician. burial-transit	FUNE	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED	13. WA	212		IGIN2 /Specify Ve		RACE — American Indian,	
a in a	BY FI	1 Never Married 2 Marrie 3 Wildowed 4 Divorced		2 NO If yes, specify Cuban, Maxico				rto Rican, etc.)	14.	Black, White, atc.  Specify:  White	
ttend e as	E	15. DECEDENT	'S EDUCATION	16a, OECED	ENT'S USUAL OCC	JPATION		16b. KIND OF BU	SINESS/INDI IS		
212 al or att for use		(Specify only higher Elementary/Secondary (0-12)	st grade completed)  College (1-4 or 5+)	(Give ki	ind of work done dur NOT use retired.)	ing most of world	ng		J., L. D. J. H. D. O. J.		
D spita	길屋	12	4	Teach	ner / Adr	ninistr	ator	Baltimon	e Cour	ntv	
G May be retained by the cross page 5 should be nust be notified at	once.	17. FATHER'S NAME (First, Middle, L	est)					rst, Middle, Maiden		ıcy	
	10 m	E. Newton Stee	lev			Eliz	abeth	Beasley	7		
	TO B	19a. INFORMANT'S NAME (Type/Prin		19b. M/	AILING ADDRESS (S					de)	
		William F. Obe		34	Rosehil:	Court	Balt:	imore. N	Marvlar	nd 21236	
	must b	20s. METHOD OF DISPOSITION  1 Street 2 Cremation 3 ( 4 C Donation 5 C Other (Specific	Ramoval from Stata	b. PLACEAND	DATE OF DISPOSITI	ON (Name of		DATE 20c. LC	CATION - City	co., Marylan	
VELTINO Jeath. Page 6 m funeral director,	iner	21. SIGNATURE OF FUNERAL SERV	NCE LICENSEE					ral Home			
hours after death. Page ed in by the funeral direx or removal.	i examiner	- Jan-	3-12-	~	140	7 Easte	rn Ave	Baltimo	ore Mar	ryland 21221	
urs after in by the		23. PART I. Enter the disease	s, or complications that cause niture. List only one cause on	d the daath.	Do not anter th	e mode of dy	ing, such as	ardiac or resp	iratory srrest	. Approximate	
filled i	E	IMMEDIATE CAUSE (Final		0			intarvei Betwee Onsat and Daat				
= 3 45	5	disease of condition resulting in death)	a. Ca	lun	ung						
omple of cre	event,	China and Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual Annual	OUE TO (OR AS	A CONSEQUEN	CE OF):						
executed with and complete o burial, crem		Sequantially list conditions,	b								
be be	traumatic	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	A CONSEQUEN	ICE OF):						
certificate ding physi	FI C	CAUSE (Disease or Injury that initiated events	C. DUE TO (OR AS	A CONSEQUEN	ICE OF):						
Certific Hydie	y, or other	resulting in death) LAST								į	
death death e attended	51 1		- a.								
at the de by the a and Merri	CAL I	PART II. Other significant cor	nditions contributing to death	but not resul	iting in the unda	riying causa (	given in Part i	. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
	8 3					,		1 TYES 2	016	COMPLETION DF CAUSE OF DEATH?	
law requires the as been signed bept, of Meaith	shows an				/				1	1 TYES 2 NO	
has be Dept.	23 s		ONTRIBUTE TO CAUSE O				ERTAIN [				
N: The State D	티디	25. WAS CASE REFERRED TO MEDI EXAMINER?	HOSPITAL:	26. PLACE OF	OTHER:	one)					
SICIAN: The Certificate the State	PHYSICI	1 YES 2 NO	1 ☐ Inpatient 2 ☐ ER/Out		OOA 4 I Nursing	Home 5 R	aldence 8 🗆 (	ther (Specify)			
PHYSIC STATE		27. MANNER OF DEATH  1 Millural 5 Pending	28s. DATE OF INJURY (Month, Day, Year)	28	INJURY	c. INJURY AT WORK?		DEŞCRIBE HOW I	NJURY OCCUR	ED	
After death		2 Accident Investig	etion			YES 2					
1 4 5 9	28 is	3 Suicide 6 Could r		r — At nome, t cify)	rarm, atreet, factory	Office	281.	OCATION (Street in City or Town, State)	and Number or F	Rurel Route Number,	
TENDIN OR: Aff		4 Homicide determined									
after 30 R:	E E	20a CERTIFIER -	29a. CERTIFIER (Check only 1 DERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.								
DIR.	It item 2	(Check only									
DIR.	ANT: It item 2	(Check only	PHYSICIAN: To the best of my know (AMINER: On the basis of examination							use(a) and manner as stated.	
HOSPITAL DR FUNERAL DIRI	It item	(Check only	CAMINER: On the basis of examination			ion, death occur	ed at the time,	date and place, an	d due to the ca	guse(s) and manner as stated.	
DIR.	PORT BE	(Check only one) 2 MEDICAL EX	CAMINER: On the beals of examination	on and/or Inves	tigation, in my opin	ion, death occur	red at the time, o	date and place, an	d due to the ca		

		1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.
		1. DECEDENT'S NAME (First, Middle, List)  EVE / 4N PARS  2. DATE OF DEATH  DAY  YEAR  6:35 PM
모		4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. Isst birthday) 1 M 2XX F 82 YRS. 8. AGE (In yrs. Isst birthday) 1 MONTHS DAYE HOURS MIN. 1 DAYE HOURS MIN. 7. DATE OF BIRTH (Month, Day, Year) 4. B. BIRTHPLACE (State or Foreign MARYLAND
2, 3 should	CTOR	Se. FACILITY NAME (If not Institution, give street and number)  SINAI HOSPITAL  BALTIMORE CITY  N/A
permit. Pages 1, 2,	DIREC	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY
		MARYLAND N/A BALTIMORE CITY  1 ★ YES 2 □ NO  100. STREET AND NUMBER  101. ZIP CODE  102. CITIZEN OF WHAT COUNTRY?
. işi	NERAL	3010 ROCKWOOD AVENUE 21215 U.S.A.
21215-0020 If or attending physician.  For use as the bunal-transit	BY FUN	11. MARITAL STATUS  1 Never Married 2 Married  1 Never Married 2 Married  3 X Wildowed 4 Divorced  12. WAS DECECENT EVER IN U.S. ARMEO FORCES? 1 YES 2 X NO FORCES? 1 YES 2 X NO Specify:  13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No— Black, White, etc.)  14. RACE — American Indian, Black, White, etc.  Specify:  15. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No— Black, White, etc.)  16. Yes 2 X NO Specify:  16. BLACK
or attend	ETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5 +)  16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  16b. KINO OF BUSINESS/INDUSTRY
HE, MARYLAND may be retained by the hospita if, page 5 should be detached is st be notified at once.	COMPL	10th grade HOUSEWIFE UNKNOWN
	w	17. FATHER'S NAME (First, Middle, Last)  18. MOTHER'S NAME (First, Middle, Maiden Surname)  JOHN F. JOHNSON  GEORGIANA COX
	TO B	19a. INFORMANT'S NAME (Type/Print)  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
		20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town. State
		MESTERN STAR CEMETERY 5/5   Baltimore, Maryland
BAL I IN er death. Pag the funeral di wal. I examiner		22. NAME AND ADDRESS OF FACILITY WILLIAM C. BROWN COMMUNITY F/H 1206 W. North Avenue
within 24 hours aft mpietely filled in by cremo cremation, or remo		23. PART I. Bater the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiec or reepiretory arrest, abook, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  OUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death 2 1 2 1 3 1 3 1 3 1 3 1 3 1 3 1 3 1 3 1
be execucian and ior to bur	CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury c.
th certification of other	ERTIFI	that initiated events resulting in death) LAST  d.
the of the linium	CAL C	PART it. Other algoriticent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PROPOSED 24b. WERE AUTOPSY FINOINGS ANALABLE PRIOR TO
signed Health	MEDIC	1 U YES 2 PNO COMPLETION OF CAUSE OF DEATH?
	AN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN
一年 書 書	SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 NO  1  NO PITAL: 1  Nursing Home 5 Residence 6 Other (Specify)
The sit of	у РНУ	27. MANNER OF DEATH  1 Natural 5 Pending (Month, Day, Year)  28a. OATE OF INJURY (Month, Day, Year)  28b. TIME OF INJURY AT WORK?  1 YES 2 NO
TTENDII CTOR: A after de 28 Is	тер ву	2   Accident investigation 3   Sulcide 6   Could not be detarmined   28e. PLACE OF INJURY — At home, farm, street, factory, office   28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
보고요는	COMPLE	29s. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and dus to the cause(s) and manner as stated.  2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dus to the cause(s) and manner as stated.
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If	TO BE CO	290. SIGNATURE AND TITLE OF CERTIFIER  BACZ M.D.  29c. LICENSE NUMBER  9701  May 2, 95
5	-	DIGEL BACZ MD SINGER OF DEATH (ITEM 27) (Typo, Print)  JOSEL BACZ MD SINGER WIND COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)  J. DATE-FILED (Morgin, Day Year)  J. DATE-FILED (Morgin, Day Year)  J. DATE-FILED (Morgin, Day Year)  J. DATE-FILED (Morgin, Day Year)  J. DATE-FILED (Morgin, Day Year)  J. DATE-FILED (Morgin, Day Year)
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BALTIMORE, MARYLAND 21215-0020

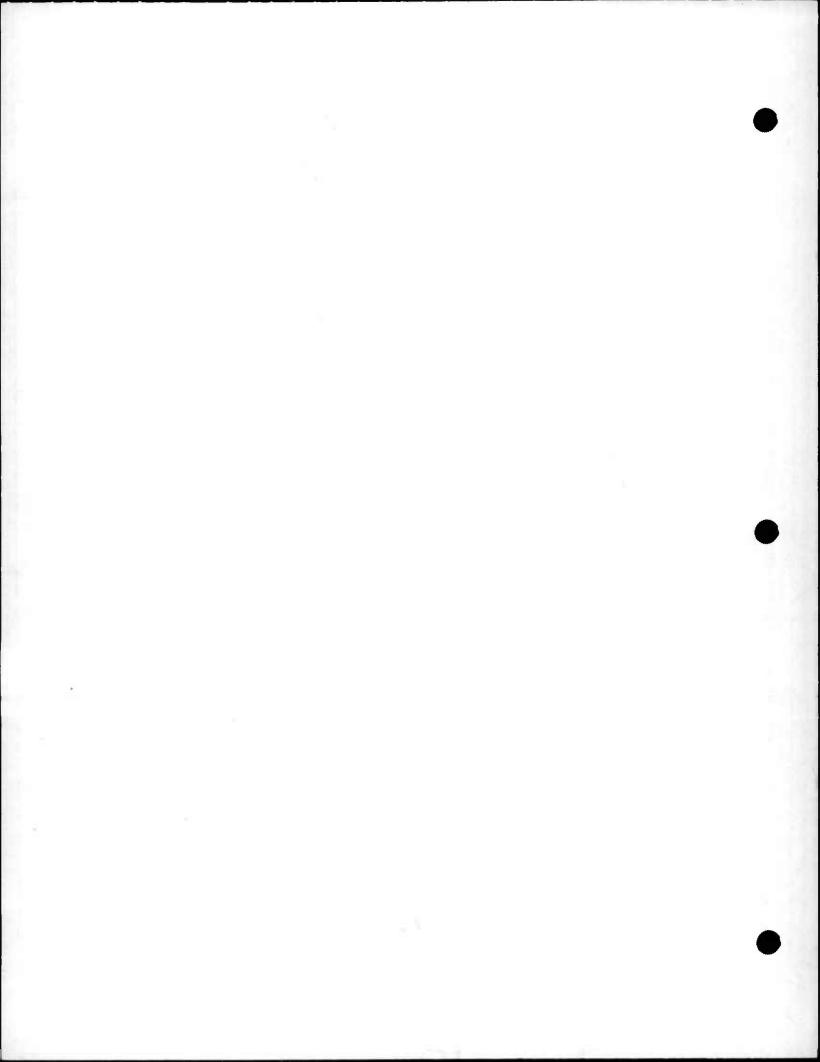
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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the Mospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Lest) MARGAR	ET I	OORIS	PA	) K	2. DATE OF DEATH MONTH DA		3. TIME OF DEATH		
	217-22-8924	1 □ M 2X□ F 68	In yrs. lest birthday) YRS.	# UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) APRIL 2, 19	8. BIRTH Countr	PLACE (State or Foreign		
DIRECTOR	9e. FACILITY NAME (If not institution, give street and number)  PENINSULA REGIONAL MEDICAL CENTER  9b. CITY, TOWN OR LOCATION OF DEATH  WICOMIC  RESIDENCE OF DECEDENT  9c. COUNTY OF DEATH  WICOMIC									
REC	10s. STATE 10b. COUNTY		1	Y, TOWN OR LOCAT				10d. INSIDE CITY		
		MERSET		PRINCESS				LIMITS?  1 YES 2 NO.		
FUNERAL	28160 MT. VERNON R	OAD		101	21853		10g. CITIZEN OF V			
ON	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC		ANIC ORIGIN? (Specify Yes	U.S.A	- American Indian,		
ВУ	1 Never Merried 2 Married 3 Widowed 4 Divorced	2 X NO	If yes, spe	2 NO Spec	can, Puarto Rican, etc.)	Black Speci	, White, etc.			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8.13)]  [Secondary (8									
PLE	Elementary/Secondary (0-12) 12TH GRADE	College (1-4 or 5+)	COSMETI			неснт	COMPANY			
OM	17. FATHER'S NAME (First, Middle, Last)	r			16. MOTHER'S N	AME (First, Middle, Maiden				
BE	JOSEPH DIMLER					ADAMS				
5	100. INFORMANT'S NAME (Type/Print) GEORGE PAK		19b. MAILING 28160	MOIINT V	ERNON R	OAD-PRINCES	n, State, Zip Code)	0 21853		
	20a, METHOD OF DISPOSITION 1 X Burial 2 Cremetion 3 Remove		PLACE AND DATE O	F OISPOSITION (Na			CATION — City or To			
	4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LICEN	L(	OUDON PA	RK CEMET	ERY D ADDRESS OF F		TIMORE			
	- James	KKI.	uc	HUBBAR	D FUNER	AL HOME INC				
	23. PART I. Enter the diseases, Dr con	nplications that caused	the desth. Do n	14107 W	ILKENS A	AVENUE-BALT	IMORE, M			
	23. PART I. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart fellure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  S									
CERTIFICATION	Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):									
MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  - End-3 tage. Roul Disease Plant Personned?  - Hyperftension  DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D									
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	26. PLACE OF DEAT	H (Check only one) OTHER:		- 1				
PHYSICIAN:	1 YES 2 NO 1	28a, OATE OF INJURY	tient 3 M DOA	4 - Nursing Home		8 Other (Specify)				
ВУ Р	1 Natural 5 Pending	(Month, Day, Year)	INJI	JRY WOI	ES 2 NO	28d. DEŞCRIBE HOW IN	JURY OCCURED			
	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Special	— At home, ferm, s	treet, factory, office		281. LOCATION (Street as City or Town, State)	nd Number or Rural R	oute Number,		
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA 2 MEDICAL EXAMINER:	IN: To the best of my knowled On the besis of examination						and manner as stated.		
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER	1. Tha	n HN		29c. LICENSE NU	0050	29d. DATE SIGNED	(Month, Day, Year)		
	30. NAME AND ADDRESS OF PERSON WHO CO	4AN 59	47-D K	Print) ) L'Veu Sun	la Dr.	. Salshy	MP.	2/8/		
	31, DATE FILEO (Month, Day, Year) MAY 0 41995	A BEGISTHAR'S SIGNA	Radall.			"				



	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	RTMENT OF I	HEALTH AND	MENTAL	HYGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	Palch		OTHY NELL	IE PALCHER	2. DATE O MONTH	DEATH DAY	7	EAR	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 220-27-7672  9a. FACILITY NAME (If not institution, give s	1 □ M 2 X 76 =	(In yrs. last birthday)  7  YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	1-3	Day, Year)	М	arylo	
TOR	Johns Hopkins Ba		l Ctr.		or Location of D timore Ci			e. COUNTY	OF DEATH	
DIRECTOR	10a. STATE 10b. COUNT	Baltimore	10c. CIT	Y, TOWN OR LOCA		lgemer	e			I. INSIDE CITY LIMITS? YES 2XXNO
FUNERAL	100. STREET AND NUMBER 6506 North Point	Road		10	H. ZIP CODE	219				country? tates
BY FUR	11. MARITAL STATUS 1 Never Married 2 Married 3 Divorced	12. WAS DECEOENT EVER II FORCES? 1 _ YES IF YES, GIVE WAR OR D	2 X NO	If yes, sp	CENOENT OF HISPA pecify Cuban, Maxic S 2 X NO Speci	an, Puerto Ric		No- 14.	Black, Wh Specify:	American Indian, illa, atc. White
LETED	15. OECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5 +)	(Give kind of life. Do NOT u		ON ost of working	16b. F	(IND OF BUSIN		TRY	WILDER
COMPLET	8 Years 17. FATHER'S NAME (First, Middle, Last) Harry Hood		Hous	ewife	18. MOTHER'S NA	AME (First, Mic				
TO BE	19a. INFORMANT'S NAME (Type/Print)  Mr. Albert L. Pa	lcher. Jr.			and Number or Rural Pt. Road	Route Number	r, City or Town,			21219
	20a. METHOD OF DISPOSITION 1 (X Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	ovel from State 20b	PLACE AND DATE	of disposition (National Property Comet	eme of EVRY 5/4	0ATE	Bal	rion - chy timor	e. MI	Stata  .~
a Kallilla	21. SIGNATURE OF FURERAL SERVICE LIKE	Tinh		22. NAME A DUO 792	NO ADDRESS OF FA la-Ruck F 12 Wise A	unera	l Home	06 D	undal	lk. Inc.
ent, the medical	IMMEDIATE CALICE (Flori	a. Public Sq. Due To (OR AS A	ach line.					ory arrest	,	Approximate interval Between Onset and Death
AL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c.	a consequence of	F):	2) 30					months
AL.	PART II. Other algolificent condition	e contributing to deeth b	out not resulting	in the underlyin	g ceuse given in		PERFORME	07	AVAI	RE AUTOPSY FINDINGS ILABLE PRIOR TO IPLETION OF CAUSE
IN: MEDIC	DID TOBACCO USE CONTI					_				YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 HO	HOSPITAL:	28. PLACE OF DEA	OTHER:	ne 5 🗆 Rasidence	8 Other (	Specify)			
ву Рн	27. MANNER OF ĎEATH  1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)		M 1	JURY AT ORK? YES 2 NO		RIBE HOW INJU			
ETED.	3 Suicide 8 Could not be determined	28a. PLACE OF INJURY building, etc. (Spec	offy)			City or	ION (Street and Town, State)		Rurel Route	Number,
COMPLET	(Check only CERTIFYING PHYSI	CIAN: To the best of my know							iuse(a) and	manner as stated.
TO BE	296, SIGNATURE AND TITLE OF CERTIFIER  30. NAME AND ADDRESS OF PERSON WH	O COMPLETEO CAUSE OF OE.	ATM (ITEM 27) /Topo	Paris	29c. LICENSE NU	8		51	GNED (Mon	ith, Day, Year)
	Steven W-In 31. DATE FILED (Month, Day, Year)	MA REMISTRATES SIGN	1940 E	astem	Avenue	- Ba	lto n	10 2	2 (20	14
	MAY 04 1995	Julia d'Audian A	artall					<u> </u>	_	OHMH-16 Ray 1/

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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the death certificate be executed within E4 hours after death. P	Inera	
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH MONTH 3. TIME OF DEATH 1995 Ε. Elizabeth Ryan May 6: 43 D M 4. SOCIAL SECURITY NUMBER 8. AGE (In vrs. last birthday) S. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS DAYS HOURS 1 M 2 X F 82 215-01-2240 Jan 13, 1913 Maryland 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Geriatrics Trinity Hebbville Baltimore RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Baltimore County 1 YES 2X NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3421 Liberty Gardens 21244 U.S.A. 11, MARITAL BTATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 🛣 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, Whits, etc. 1 Never Married 2 Married If yes, specify Cuben, Mexican, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES 1 TES 2 X NO Specify: BY 3 X Widowed 4 Divorced Specify: White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Unknown Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) ĕ James Murphy BE Rose McKeever notified 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Margaret Mumma 3506 Melody Lane Baltimore, MD 21244 pe 20s. METHOD OF DISPOSITION
1 ◯ Burlel 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 29c. LOCATION - City or Town, State must New Cathedral Cemetery 4 Donation 5 Other (Specify) 5/4 Baltimore, Maryland examiner 21. SIGNATURE OF PUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133 medicai 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, Approximate shock, or heart feliure. List only one ceuse on each line. Interval Between **IMMEDIATE CAUSE (Final Onset and Death** the diseese or condition sendocepst 100 ancrea event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditione, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING other t CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 injury, PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. BY PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE any TYES 2 NO OF DEATH? shows 9 01 ocu 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) item HOSPITAL: OTHER; 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 0 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME O 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Netural 5 Pending Investigation М 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) .49 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 28 4 Homicide It item 29s. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and menner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and man TO THE HOSPITA
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IMPORTANT: II 296. SIGNATURE AND THE OF CERTIFIER ED (Malphim, Day: Year) BE

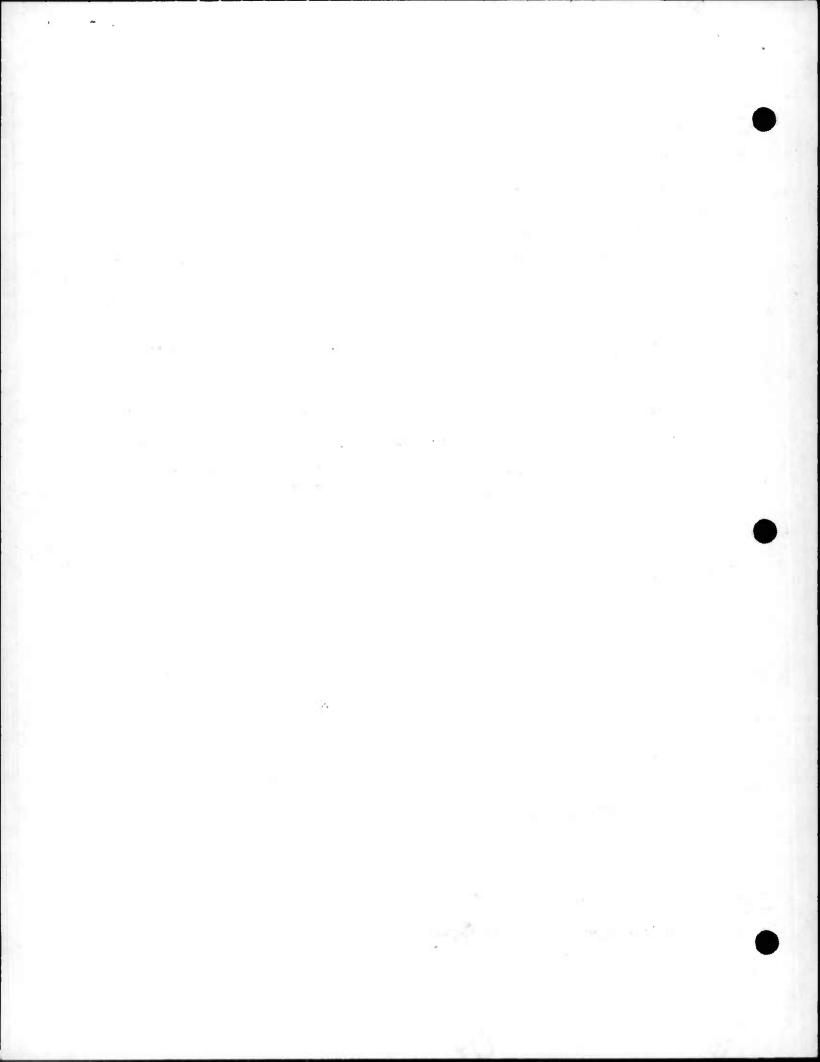
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)

WAJA

32. REGISTRAR'S SIGNATURE

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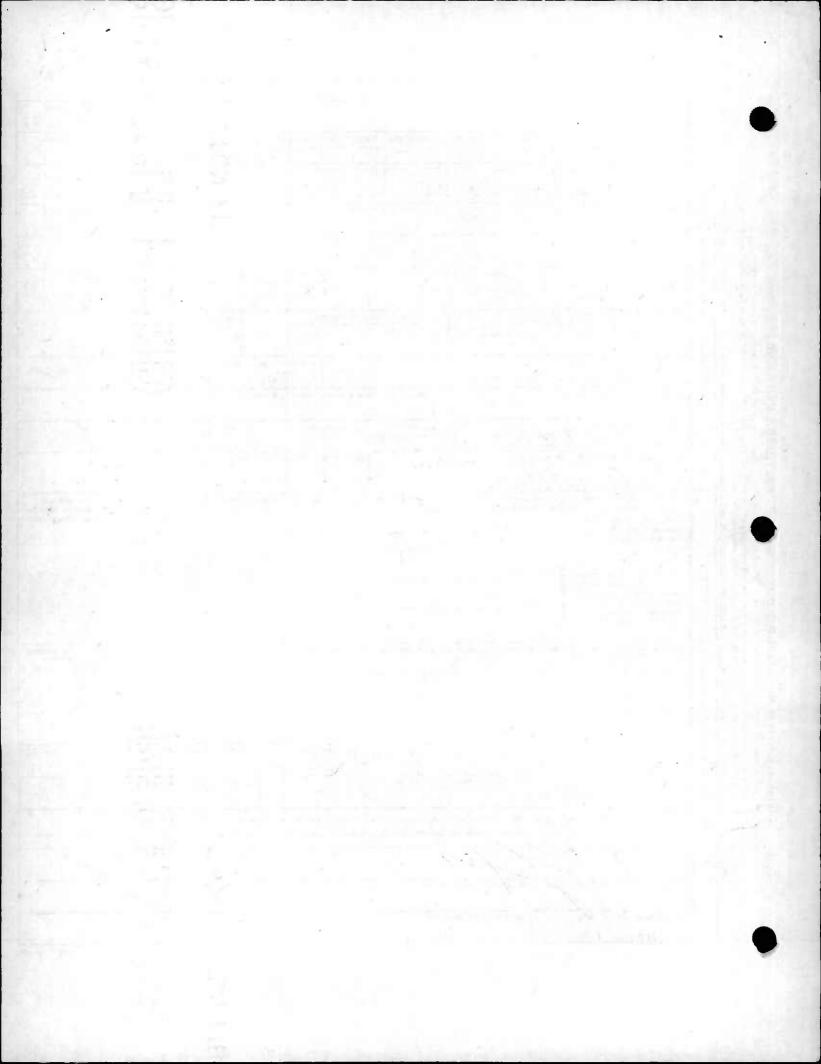
<b>BALTIMORE, MARYLAND 21215</b>	quires that the death certificate be executed with
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ECORDS, P.O. BOX 68760	certificate
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1 - FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH 8:20A M K033 Jama 4. SOCIAL SECURITY NUMBER 5 SEX 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. 7. DATE OF BIRTH (Month; Day, Year 8. BIRTHPLACE (State or Foreign Month; Day, Your)
4/11/95 1 M 2 - F Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) DIRECTOR Medical Center Baltimore DECEDENT 10a. STATE VOL. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY YES 2 NO 70 permit, FUNERAL 10s. STREET AND NUMBER 10g. CITIZEN OF WNAT COUNTRY? the burial-transit 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-It yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. tt yes, specify Cuben, Mexican, Puerto Rican,

1 YES 2 NO Specify: 1 Never Married 2 Married Specify: B В 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.) use 16b. KIND OF BUSINESS/INDUSTRY 10 Elementary/Secondary (0-12) College (1-4 or 5+) detached 17. FATNER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Meiden Surname) Williams notified at James BE ene funeral director, page 5 should 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Tene Ross Pe 20e, METNOO OF DISPOSITION
1 | Burlet 2 | Cremetton 3 | Regnoval from State
4 | Donation 6 | Other (Specify) | ID | STATE 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must 21. SIGNATURE OF FUNDRAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY State Anatomy Board or other traumatic event, the medical examiner Ronald Wade, Dir. 655 W. Baltimore St., Balto., MD 21201 all in by the 23. PART I. Enter the disesses, or complications that caused the dasth. Do not anter the mode of dying, such as cardiac or respiratory street, Approximate shock, or haart failure. List only one cause on each line. 0 IMMEDIATE CAUSE (Final Onset and Death and completely fille burial, cremation, disesse or condition tmamput resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): attending physician a mal Hygiene prior to if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated avents DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST the atten injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINOINGS and and AVAILABLE PRIOR TO COMPLETION OF CAUSE shows any Signed Health a 1 TYES 2 NO OF DEATH? 1 TYES 2 NO this certificate has been a with the State Dept. of PHYSICIAN: HOSPITAL OR ATTENDING PHYSICIAN; The law DIVISION OF VITAL 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) HOSPITAL: OTHER: 1 TES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 5 Residence 6 Other (Specify) 10 26e. OATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 26b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural BY 1 YES 2 NO DIRECTOR: After the hours after death vitem 28 is mark 2 Accident 26e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Nomicide 29e. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) end menner es stated. FUNERAL I 2 MEDICAL EXAMINER: On TO THE HOSPITA
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IMPORTANT: 1 tion, in my opinion, death occured at the time, date end place, end due to the ceuse(s) end menner ee stated, 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2 COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE FILED (Month, Day, Mar) 32. REGISTRAR'S SIGNATURE

1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The Jaw requires that the death certificate be executed within Juns after death. Page 6 may be retained by the hosy	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely nic in by the funeral director, page 5 should be detache	ga.	IMPORTANT: If Nem 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR 1 STATE	STATE OF MAI					MENTAL HYGIEN	E	
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	4. SOCIAL SECURITY NUMBER 141-03-7136		AGE (In yrs. last birth	RS. MONTH	DER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH	200	BIRTHPLACE (State or Foreign Country) New Jersey
TOR	on FACILITY NAME (If not institution, give schese pecke heal)	hoore & Re	ehzb. Ctr		AMC	R LOCATION OF DE	EATH		e Arundel
DIRECTOR	10e. STATE 10b. COUNT	e Arund	e 100		NOR LOCAT	ION			10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL		= Parku				2101Z		u	S 4
B₹	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EN FORCES? 1 IT IF YES, GIVE WAR	YES 2 NO		If yes, spe		NC ORIGIN? (Specify Yea in, Puarto Rican, atc.) y:	or No — 1	4. RACE — American Indien, Black, White, etc. Specify Wh JZ
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(Give kir life. Do h	ent's USUA nd of work do NOT use retire	L OCCUPATION OF COLOR	ON st of working	16b. KIND OF BU	SINESS/INDU	STRY
BE COM	17. FATHER'S NAME (First, Middle, Last) Fortunato Raymo	ond	110	illare	5561		ME (First, Middle, Maiden		
10 B	19e. INFORMANT'S NAME (Type/Print)  Cynthia Capone		- 1				Annapolis		21403
	20a. METHOD OF DISPOSITION  1  Burlel 2  Cremation 3  Ram 4  Donation 5 Other (Specify)	noval from State				metery, crematory or			Ity or Town, State
	21. SIGNATURE OF FUNERAL SERVICE LI	Ronald	Wade, D	ir.			CILITY State A		y Board o., MD 21201
	23, PART I. Enter the diseeses, or shock, or heart fellure.	complications that co	sused the death.	Do not er	nter the mo	de of dying, euc	h ee cerdlec or resp	retory erre	et, Approximate Interval Between
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A	ITO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the but within 72 hours after death with the State Deut of Health and Mental Hydiene prior to burial, cremation, or removal.	THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE P
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a viours after death. Page 6 may be retained by the hospital or attending phy	25	

		FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPART			MENTAL HYGIENI REG. NO.	Ε	
		1. DECEDENT'S NAME (First, Middle, Last)  David	ELLIS	ROACH			2. DATE OF DEATH	1995 YEAR	3. TIME OF DEATN 8:50 A M
		4. SOCIAL SECURITY NUMBER 216-24-2141	5. SEX 6. AGE		F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) NOV 24, 1	6. BIRT	THPLACE (State or Foreign intry)
2, 3 should	OR	98. FACILITY NAME (If not institution, give str Franklin Square		S	ROSSU	or LOCATION OF DI		9c. COUNTY OF Baltim	DEATN
FOU.  STATIS—UNZU  THE MICHAEL INFORME, MARY FLAND 21215-UUZU  THE MICHAEL MICHAEL Page 6 may be retained by the hospital or attending physician.  Completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 ial, cremation, or removal.  Event, the medical examiner must be notified at once.	DIRECTOR	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY  Virginia	101	10c. CITY,	TOWN OR LOCAT		zet		10d. INSIDE CITY LIMITS?
		100. STREET AND NUMBER  Rt. 2 Box 87	<u>Albemarle</u>		10f	. ZIP CODE			1 YES 2 NO WHAT COUNTRY?
	FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1% YES	2 NO	If yes, sp	ENDENT OF NISPAI	NIC ORIGIN? (Specify Yearin, Puerto Rican, atc.)	or No — 14. RAC	d States CE - American Indian, ok, White, etc.
	ED BY	3 Widowed 4 Divorced  15. DECEDENT'S EDUC	IF YES, GIVE WAR OR C	WWII	SUAL OCCUPATION	2 X NO Specifi	16b. KIND OF BUS		White
	COMPLET	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT use	rk done during mo retired.) Metal W			Metal II	adus + nu
		17. FATHER'S NAME (First, Middle, Last) Lively Wilson Roc	ıch	, 0,,000	MOCEUCE W	18. MOTNER'S NA	ME (First, Middle, Maiden S Jettie Fraz	Surname)	ruusizig
	TO BE	19a. INFORMANT'S NAME (Type/Print)  Davetta Gay Mitte		19b. MAILING A	ODRESS (SIRE)	nd Number or Rural	Floure Number, City or Town	n, State, Zip Code)	1027 21220
		20s. METHOD OF DISPOSITION 5 Burlel 2 Cremation 3 Ramor 4 Donation 5 Other (Specify)	val from State 20	b. PLACEAND DATE OF metery, cremetory or othe COCKGATE	DISPOSITION (Na	me of	DATE 20c. LOC	cation - City or Zet. Vi	Town, Stata
		21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE Res	2	Duda-	RUCK FUN		of Dunde	alk. Inc.
		23. PART I. Enter the diseases, or consher fallers. L. IMMEDIATE CAUSE (Final disease or condition resulting in death)	Severe re	aach lina.	t antar tha mo	da of dying, auc	h aa cardiac or reapir	atory arreat,	Approximate interval Between Onest and Death 2 weeks
and and bur	CATION	Sequentially list conditions, if any, leading to immediate		ization to	multi	ple plat	elet transi	fusions	3 months
certificat nding phy Hygiene p	RTIFI	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE OF):				<u> </u>	
nat the death of the atternal and Mental w injury, o	L CE	PART II. Other algnificant conditions	contributing to death	but not resulting in	the underlying	cause givan in	Part I. 24a. WAS AN	AUTOPSY 24	b. WERE AUTOPSY FINDINGS
signed by Health and	MEDICAL	liver masses, pr anemia, Busulpha	obable meta	static car	ncer, s	iderobla		MED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?  1 YES 2 NO
1 % o b 8	AN.	bleeding 25. WAS CASE REFERRED TO MEDICAL							
E ## E	SICIAN:	EXAMINER?	HOSPITAL:		THER:	ACE OF DEATH (Ch	6 Other (Specify)		
를 를 를 들	ву рну	27. MANNER OF DEATH  1 X Natural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME (	Y WO	URY AT RK? /ES 2 NO	28d. DESCRIBE NOW IN	IJURY OCCURED	
DR ATTENDING DIRECTOR: After hours after death tem 28 is ma		3 Suicide 6 Could not be 4 Homicide detarmined	28s. PLACE OF INJUR building, etc. (Spe	Y — At home, farm, streedly)	et, factory, office		281. LOCATION (Street as City or Town, State)	nd Number or Rural	Route Number,
= 25 1/2	COMPLETE		IAN: To the beat of my know						(a) and menner as stated.
TO THE HOSP TO THE FUNEI De filed within	TO BE	-00-0 7	andsen r			DY 63		PAP	7, 1995
17	-	30. NAME AND ADDRESS OF PERSON WHO Carol Richard				uare Dri	ve Baltimo	ore, MD	21237
		MAY 04 1995	32. REGISTRAR'S SIGN	NATURE Ordall					

1995

9c. COUNTY OF DEATN

NA

10g. CITIZEN OF WNAT COUNTRY?

USA

40

None

3. TIME OF DEATN

B. BIRTHPLACE (State or Foreign

10d. INSIDE CITY

14. RACE — American Indian, Black, White, atc.

1 X YES 2 NO

Black

MD

Approximate

interval Between

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24b. WERE AUTOPSY FINDINGS

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Maryland

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2. DATE OF DEATH

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FOR STATE REGISTRAR

1. DECEDENT'S NAME (First Middle Last)

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4. SOCIAL SECURITY NUMBER B. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Morith, Day, Year) 09 30 5 SEY IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 XX 54 214-38-1224 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATN UNJON MEMORTAL DIRECTOR HOSPITK BALTIMORE CLT RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION Marvland NA Baltimore City permit. FUNERAL 10a. STREET AND NUMBER filled in by the funeral director, page 5 should be detached for use as the burial-transit 2773 The Alameda 21218 Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Maxican, Puerto Rican, atc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 AND FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 X Married BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 NA Homemaker 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Cherry (Sanderlin) notified at James Sanderlin BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Francine Curbeam 1907 Wadsworth Way Balto, MD 21239 99 20s. METHOD OF DISPOSITION
1 X Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must ☐ Donation 6 ☐ Other (Specy) King Memorial Park 5/8/95 Baltimore, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY hours after death. Unity Funeral Home 108 W. North Avenue Balto, medical 23. PART I. Enter the diseases, or complication, that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feliure. Liet only one cause on each line. 6 IMMEDIATE CAUSE (Final the disease or condition_ DISTRESS SYNDROME attending physician and completely mal Hygiene prior to burlal, crematic ADUlt RESPIRATORY reaulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): Neumonia traumatic CERTIFICATION Sequentially list conditions. 2 DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING DIVISION OF VITAL RECORDS, P.O. BOX requires that the death certificate be signed by the attending physiciar Health and Mental Hygiene prior FaILURE ENAL CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY MEDICAL PERFORMED? shows any mellitus 1 TYES 2 NO to DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be Dept. S 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OR ATTENDING PHYSICIAN: The EXAMINER? HOSPITAL:
1 Number | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 DOA | 1 certificate I 4 Nursing Nome 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? After this ce leath with the marked, 26d. DESCRIBE NOW INJURY OCCURED 1 Natural
2 Accident 5 Pending Investigation 1 YES 2 NO BY After death DIRECTOR: Aft hours after deal ltem 28 is n 3 Suicide 26s. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide determined 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 h HOSPITAL MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. HOL BIGHATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE ellerer MD

ESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

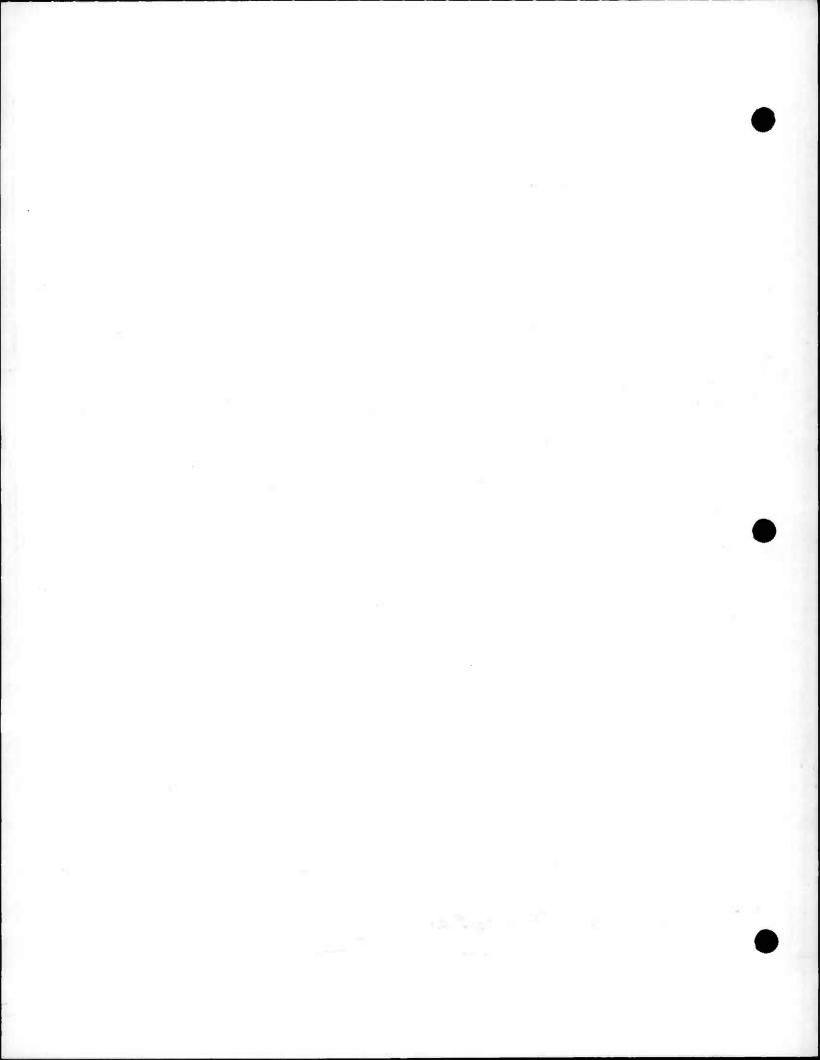
Union HemoRial HOSPITAL

Kelleher

RICHARDSON

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

> AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 | YES 2 | NO 29d. DATE SIGNED (Month, Day, Year) 1995 MAY 2, DHMH-16 Rev 1/89



Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR BAYVIEW HOSPITAL BALTIMORE RESIDENCE OF DECEDENT 10h COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND BALTIMORE N/A permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE funeral director, page 5 should be detached for use as the bunial-transit 5409 PLAINFIELD AVE hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 □ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married BY 3 Widowed 4 Divorced WWII-NAVY COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) intary/Secondary (0-12) College (1-4 or 5+) MANAGER once. 17. FATHER'S NAME (First, Middle, Last) Ħ BE SAMUEL ROSEN notified 19a. INFORMANT'S NAME (Type/Print) 2 FRIEDMAN KARREN ě 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of must 1 Donation 6 Other (Specify) °RADOMER °VEREIN medical examiner 21. SIGNATURE 22. NAME AND ADDRESS OF FACILITY this certificate has been signed by the attending physician and completely filled in by the with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. 23. PART I. Enter the diseases or complications that caused the death. Do not enter IMMEDIATE CAUSE (Final the diseese or condition event. reculting in deeth) HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760 other traumatic CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events reaulting in death) LAST 0 PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL shows any DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MINITCAL 1 YES 2 ZW MANINER DE DE 28s. DATE OF IN marked, BY After after de COMPLETED DIRECTOR: Item TO THE FUNERAL D be filed within 72 ho IMPORTANT: If IN BE 2

FOR STATE REGISTRAR

SYDNEY

4. SOCIAL SECURITY NUMBER

215-12-2762

1. DECEDENT'S NAME (First, Middle, Last)

J.

S. SEX

1 M 2 | F

6. AGE (In vrs. last birthday)

79

u 4 1995

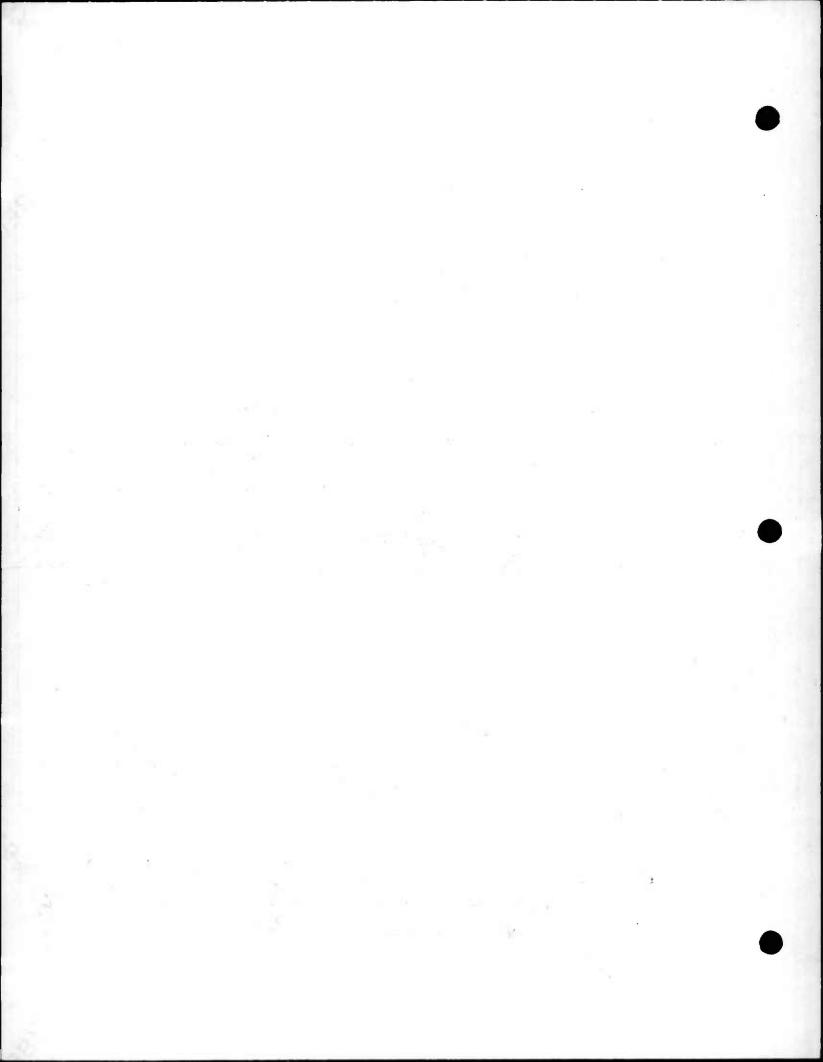
95 | 339 |

ROSEN

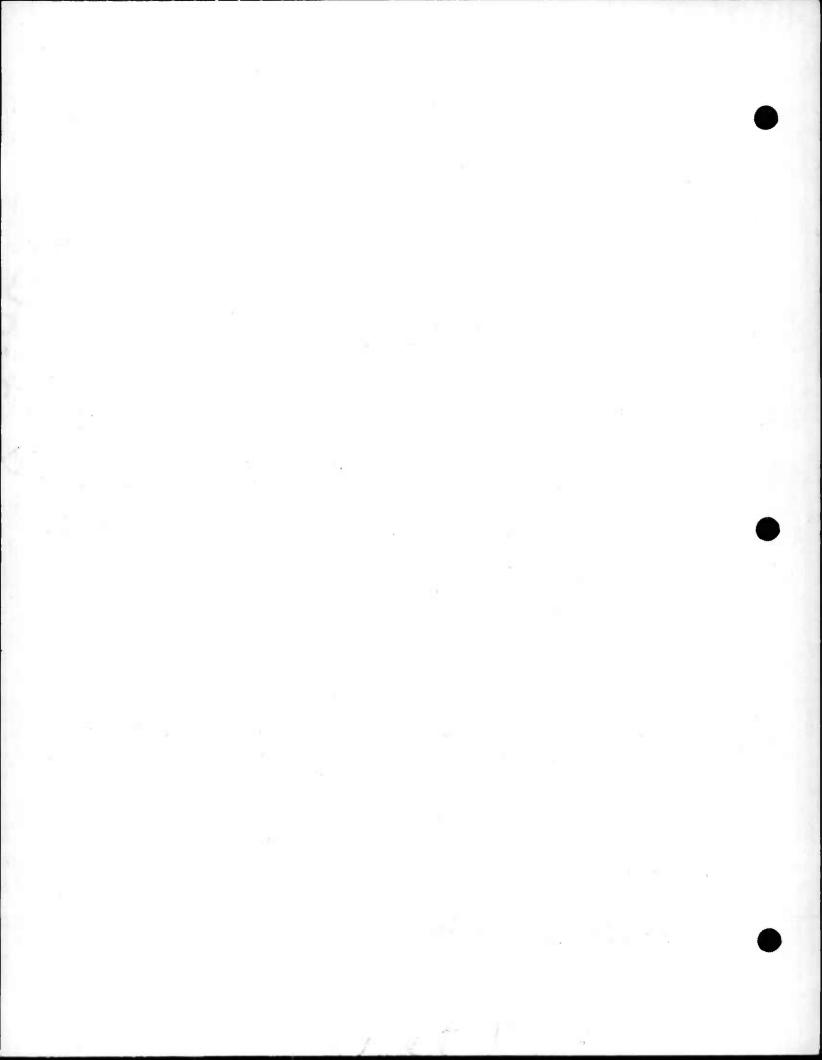
HOURS

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 2. DATE OF DEATH 3. TIME OF OFATH APRIL 30,1995 5:38PM 7. DATE OF BIRTH
(Month, Day, Year)
NOV. 23, 1915 IF UNDER 1 YEAR IF UNDER 24 HRS. MARYLAND 9c. COUNTY OF OEATH N/A 10d. INSIDE CITY 1 X YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? 21206 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—if yea, specify Cuban, Mexican, Puarto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. Specify: WHITE 16b. KIND OF BUSINESS/INDUSTRY HILLMAN BREWERY 18. MOTHER'S NAME (First, Middle, Maiden Surname) ROSE UNKNOWN 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 TANNER COURT BALTIMORE, MD 21208 DATE 20c. LOCATION — City or Town, State 5-2-1995 ROSEDALE, MD SOL LEVINSON & BROS., INC. REISTERSTOWN ROAD BALTIMORE 2121 ng, such ae cardiac or reapiratory arrest, Approximata Interval Between Onset and Death 24s. WAS AN AUTOPSY 14b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 281, LOCATION Rural Route Number



		1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.											
		t. DECEDENT'S NAME (First, Middle, Lest)  Edna Bertha	REID				2. DATE OF DEATH MONTH May 1,1995				TIME OF DEATH		
BALTIMORE, MARYLAND 21215-0020  re death. Page 6 may be retained by the hospital or attending physician.  the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should val.  is examiner must be notified at once.	DIRECTOR	4. SOCIAL SECURITY NUMBER 217 20 4935	In yrs. last birthday) 87 YRS.	y) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year)					La presure de la				
		96. FACILITY NAME (If not institution, give stre Franklin Square Ho	er	96. CITY, TOWN		%c. COUNTY OF DEATH Baltimore							
		RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		tec. C/I	Y, TOWN OR LOCA	TION				Lea	d. INSIDE CITY		
		Maryland Baltim		Middle River						LIMITS?  YES 2 NO			
	FUNERAL	1607 Aldeney Avenu		10					COUNTRY?				
	CNE	11. MARITAL STATUS	U.S. ARMED	21220 RMED 13. WAS DECENDENT OF HISPANIC ORIGIN					J.S.A	American Indian.			
	ВУ	1 Never Married 2 Married 3 Wildowed 4 Divorced	2 ONO TES	If yes, specify Cuban, Mexicen, Puerto Rican, etc.)  1  YES 2 NO Specify:					specify White				
	TO BE COMPLETED	ts. DECEDENT'S EDUCA (Specify only highest grade of	16s. DECEDENT'S (Give kind of	T'S USUAL OCCUPATION of work done during most of working T use retired.)				IND OF BUSINESS/INDUSTRY					
		Elementary/Secondary (0-12)		ousewife									
		17, FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NAME (First, Middle, Malden Surname)								
		Samuel Robinso	n			Cornel			gger				
		tea. INFORMANT'S NAME (Type/Print)  Darlene Reid				and Number or Rural					21220		
may be or, page t		20s. METHOD OF DISPOSITION	20b.		OF DISPOSITION (NA	Ave. Mic	DAT		CATION — CR				
AOR ge 6 ma irector, p		t  Burtal 2  Cremation 3  Remov	al from State   ceme	etery, cremetory or o	Memorial		1/95		imore				
ALTIN death. Pag tuneral dir f. examiner		21. SIGNATURE OF FUNERAL SÉRVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY  Bruzdzinski Funeral Home P.A.											
BALTIMORE, after death. Page 6 may be by the funeral director, page smoval.		1407 Eastern Ave Baltimore, Maryland 21221											
B, hours after led in by the removal a medical		23. PART I. Enter the disesses, or complections that sused the death. Do not enter the mode of dying, such as cardisc or raspiratory errest, shock, or hasn't fellure. List only one ceuse on each line.  IMMEDIATE CAUSE (Finel											
P.O. BOX 68760 th certificate be executed within 74 hours ending physician and completely filled in it Hygiene prior to burial, cremation, or re or other traumatic event, the med	CERTIFICATION	disease or condition ————————————————————————————————————									2days		
		_	DUE TO (OR AS A		•						0.1		
OX 68 e be execute sician and c rrior to buria traumatic		Sequentielly list conditions, If smy, leeding to immediate  Myocardial infarction  Due to (or as a consequence of):									2days		
BOX ficate be physician ne prior to	CA	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events  DUE TO (OR AS A CONSCOUENCE OF):								20years			
P.O. B th certificat ending phy Hygiene p or other	ATE	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST							-				
		d.											
三路 草 五	CAL	PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED?  A PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED?  A PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED?								AWA	RE AUTOPSY FINDINGS ILLABLE PRIOR TO MPLETION OF CAUSE		
RECO requires the been signed t. of Health a	MEDI	Chronic renal insufficiency							OF	OF DEATH?			
S of be see									1				
TA The ate h	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	8. PLACE OF DEA	TH (Check only one) OTHER:								
PHYSICIAN: this certifical with the St riked, or it	14SI		Inpatient 2 ER/Output		4 - Nursing Hom	e 5 🗆 Residence	1						
		1 Natural 5 Pending	(Month, Day, Year)	28b. TIM	E OF URY WORK? 28d. 1 YES 2 NO		28d. DE	28d. DESCRIBE HOW INJURY OCCURED					
TTENDI TTOR: A after de	тер ву	2 Accident Investigation 3 Suicide 8 Could not be determined	street, factory, office 281, LOCATIO			CATION (Street as or Town, State)	TION (Street and Number or Rural Route Number, Town, State)						
크 크 이 누	COMPLETED	29s. CERTIFIER (Check only one)  1 MEDICAL EXAMINER: On the beats of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.											
HOSPITAL FUNERAL WITHIN 72 I	E CO									SIGNED (Month, Day, Year)			
TO THE HOSPIT TO THE FUNERA Be filed within 7	TO BI	(Kurdytph Cal	s moo	0-cen D44918			> 5/1/95			-			
10		30. NAME AND ADDRESS OF PERSON WHO Dr. Randolph DeCa				. Baltir	nore,	Maryl	and 2	1237			
		MAY 0 4 1995	32. BEGISTRAR'S SIGNA	TURE							***		



**BALTIMORE, MARYLAND 21215-0020** 

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3. TIME OF DEATH										
95 4:35 A M										
8. BIRTHPLACE (State or Foreign Country) Maryland										
ITY OF DEATH										
timore										
10d. INSIDE CITY LIMITS? 1 ☐ YES ②【☐ NO										
ZEN OF WHAT COUNTRY?										
14. RACE — American Indian, Black, White, etc. Specify:										
White										
C-122										
EV.										
/										
Code)										
1d. 21224										
City or Town, State										
1) Surfal 2 Cremellon 3 Removal from State   cemelory, crematory or other place  4 Donestion 5 Other (Specify) Parkwood Cemetery 5/5/95   Baltimore MD.										
of Essex										
MA 21221										
Md. 21221										
aat, Approximate Interval Between										
aat, Approximate										
aat, Approximate Interval Between										
Approximata Interval Between Onset and Daeth  1 day										
Approximate Interval Between Onset and Daeth										
Approximata Interval Between Onset and Daeth  1 day										
Approximata Interval Between Onset and Daeth  1 day										
Approximata Interval Between Onset and Daeth  1 day										
Approximata Interval Between Onset and Daeth  1 day										
Approximata Interval Between Onset and Daeth  1 day  21 days										
Approximata Interval Between Onset and Daeth  1 day  21 days										
Approximata Interval Between Onset and Daeth  1 day  21 days										
Approximata Interval Between Onset and Daeth  1 day  21 days  24b. WERE AUTOPSY FINDINGS APAILABLE PRIOR TO COMPLETION OF CAUSE										
Approximata Interval Between Onset and Daeth  1 day  21 days  24b. WERE AUTOPSY FINDINGS APAIL ABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?										
Approximata Interval Between Onset and Daeth  1 day  21 days  24b. WERE AUTOPSY FINDINGS APAIL ABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?										
Approximata Interval Between Onset and Daeth  1 day  21 days  24b. WERE AUTOPSY FINDINGS APAIL ABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?										
Approximata Interval Between Onset and Daeth  1 day  21 days  24b. WERE AUTOPSY FINDINGS APAIL ABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?										
Approximata Interval Between Onset and Daeth  1 day  21 days  24b. Were Autopsy Findings Amil Able Prior to Completion of Cause Of Death?  1 Yes 2 No										
Approximata Interval Between Onset and Daeth  1 day  21 days  24b. Were Autopsy Findings Amil Able Prior to Completion of Cause Of Death?  1 Yes 2 No										
Approximata Interval Between Onset and Daeth  1 day  21 days  24b. Were Autopsy Findings Amil Able Prior to Completion of Cause OF Death?  1 Yes 2 No										
Approximata Interval Between Onset and Daeth  1 day  21 days  24b. WERE AUTOPSY FINDINGS APAIL ABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO										
Approximata Interval Between Onset and Daeth  1 day  21 days  24b. WERE AUTOPSY FINDINGS APAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO										
Approximata Interval Between Onset and Daeth  1 day  21 days  24b. WERE AUTOPSY FINDINGS APAIL ABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO										
Approximata Interval Between Onset and Daeth  1 day  21 days  24b. WERE AUTOPSY FINDINGS APAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO										
Approximata Interval Between Onset and Daeth  1 day  21 days  24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  URED  OF Rural Route Number,  d. cause(s) and menner as stated.										
Approximata Interval Between Onset and Daeth  1 day  21 days  24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  URED  OF Rural Route Number,  d. cause(s) and menner as stated.										
Approximata Interval Between Onset and Daeth  1 day  21 days  24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO  URED  OF Rural Route Number,  d. cause(s) and menner as stated.										

FOR 1 - STATE

ITEMS: 23 PART 1,27 PER MEO G-723 5/19/95 reb
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		_	REGISTHAH				CERTIF	ICATE C	OF DEATH		REG. NO.				
			1. OECEDENT'S NAME (First, Middle, Lest) ELIZABETH								2. DATE OF DEATH STATE OF DEATH S. 3. TIME OF DEATH 5:32A				
. 2. 3 should	,		4. SOCIAL SECURITY NUMBER 218-38-3680		5. SEX 6. AGE (In yrs. lest birthday) 1 🗆 M 2 🖾 F 52 YRS.		IF UNDER 1 YE MONTHS DA	EAR IF UNDER 24 HRS. AYB HOURS MIN.	7. DATE 0 (Month, 8/1	7. DATE OF BIRTN (Month, Day, Year) 8/13/42		a. BIFTNPLACE (State or Foreign Country) MI			
	, s	DIRECTOR	99. FACILITY NAME (If not institution, give street and number) 4113 GRENTON AVE.						96. CITY, TOWN OR LOCATION OF DEATH Baltimore City.				Baltimore City		
-		<u>입</u>	RESIDENCE OF DECED	COUNTY			I 10c CIT	Y TOWN OR I	OCATION						
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit permit. Pages 1, 2.			MD  100. STREET AND NUMBER	100.01			ry, town or Location altimore						d. INSIDE CITY LIMITS? YES 2 NO		
		FUNERAL	4113 Grenton Ave						21206				109. CITIZEN OF WHAT COUNTRY? USA		
		À	11. MARITAL STATUS  1			YES	S 2 NO If yes, specify Cuban, Mexican			an, Puerto R	n, Puerto Rican, etc.) Bio			American Indian, Thita, etc.	
			15. DECEDER (Specify only high			- 1	IGA. DECEDENT'S	USUAL OCCU	PATION	16b.	KIND OF BUS	SINESS/INDUS	TRY		
		COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)		+)	(Give kind of work done during most of life. Do NOT use retired.)  housewife			own home			e			
AN he ho	once.	Ö	17. FATNER'S NAME (First, Middle	,					16. MOTHER'S N						
YL	16	BEC	unknown	_	WILLIAM WH	ITE		Elizabeth Francis							
MARYLAND retained by the hospit 5 should be detached	notified	10 B	19a. INFORMANT'S NAME (Type/F				19b. MAILING	ADDRESS (St	reet and Number or Rura	Route Number	or, City or Town	n, State, Zip Co	ode)		
	92	۲	Jacqueline	Stew	art		3214	Pelhan	a Ave., Ba	ltimo	re, MI	212			
BALTIMORE, after death. Page 6 may be by the funeral director, page	st be		20a. METHOD OF DISPOSITION 1 Buriel 2 Cremation	□ Dame	uml from State	20b. P	LACE AND DATE	OF OISPOSITIO	N (Name of	DATE	20c. LO	CATION — CIT	y or Town,	State	
O P	must		4 Donation 5 Other (Spe		Wei from State	_ Ca	rroll C	remati	on Servic	e 5/3	95 H	lampst	ead.	MD	
F 26 25	i i		21. SHOWATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 11824 Reisterstown Rd.												
AL death	- exa		Eline Funeral Home Reisterstown, MD 21136												
afe on	removal dical		23 DAST I Enter the disease or completeless that sound the dast of												
y filled in	on, or re		Approximate interval Between Onset and Death  Approximate interval Between Onset and Death  CIRRHOSIS OF LIVER												
60 with	vent	į	resulting in death)		DUE TO	(OR AS A C	ONSEQUENCE O	F):							
executed and com	o buria	Sequentially list conditions, if arry, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  d.													
eath certificate be eatherding physician a	Mental Hygiene prior ijury, or other trau	SAT I	If any, leading to immediate cause. Enter UNDERLYING												
O. B. certificate ding physi	the t	Ĕ	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):												
P.O. orti	Br o	토	resulting in death) LAST												
OS, P he death the atten		T I	DART II ON I - III - A												
~ = à	Health and Menta	EDICAL	PERFORMED? AMAILABLE PRIOR							RE AUTOPSY FINDINGS MLABLE PRIOR TO MPLETION OF CAUSE DEATH?					
	show	2								YES 2 NO					
law bas by	State Dept. of H	SICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN												
VITAL JIAN: The law	State Dept	호	25. WAS CASE REFERRED TO MEDICAL  26. PLACE OF DEATH (Check only one)  EXAMINER?  HOSPITAL:  OTHER:  27.												
F VIT,	the S	HYS	1 XYES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)												
O \( \frac{1}{2} \)	Ked	BY PH	27. MANNER OF DEATH  Natural 5 Pond 2 Accident Inves	INJURY Pay, Year)	28b. TIME OF INJURY AT WORK?  M 1 YES 2 NO			28d. DE\$C	DESCRIBE HOW INJURY OCCURED						
TISIC TTENDI TTENDI TOR: A after d		ETED	3 Suicide 6 Could not be 4 Homicide determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						office	26f. LOCATION (Street and Number or Flural Route Number, City or Yown, State)					
DI HOSPITAL OR FUNERAL DIRI	2=	COMPL	29s. CERTIFIER (Check only one)  22 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the films, date and place, and due to the cause(a) and manner as stated.  MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and menner as stated.												
보 보	DRTA wi	шШ	296. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, You							onth, Day, Year)					
37 CF	be filed within	<u>ه</u> ا	mante breffull					O.C.M.E.				MAY 02 1995			
		임	DO. NAME AND ADDRESS OF PER	SON WNO	COMPLETED CAUS	SE OF DEAT	N (ITEM 27) (Type,	Print)							
			TPHYPHUDO	11.16	okul w	. 111	Penn	Stree	et, Balti	imore	, Ma:	rylan	d 2:	1201.	
2			31. DATE FILED (Month, Day, Year)	11	22. REGISTRA							-			

296. SIQNATURE AND TITLE OF CERTIFIER

04 1995

MORK

31. DATE FILED (Month, Day, Year)

30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

BE

2

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR DR. JOSEPH SHULMAN APRIL 30,1995 3:300m4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year)
FEB. 7,1909 8 SEY 6. AOE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 X M 2 - F 86 470-14-3238 LITHUANIA 9a. FACILITY NAME (If not institution, give atreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Pages 1, 2, 3 6711 PARK HEIGHTS AVE APT. 212 BALTIMORE N/A RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY FLORIDA PALM BEACH BOCA RATON 1 X YES 2 NO funeral director, page 5 should be detached for use as the burial-transit permit. FUNERAL 104. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21815 ARRIBA REAL, APT. 1211 33433 USA hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, DIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Maxican, Puerto Rican, etc.)
 \[ YES 2 \infty \ NQ \quad Specify: \] 14. RACE - American Indian, Black, White, etc. **BALTIMORE, MARYLAND 21215-0020** 1 Never Married 2 Married B 3 Widowed 4 Divorced WWII WHITE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) DENTIST DENTISTRY 17. FATHER'S NAME (First, Middle, Last) WILLIAM 18. MOTHER'S NAME (First, Middle, Malden Surname)
BESSIE SHULMAN FISHER 76 BE notified 19s. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 6711 PARK HEIGHTS AVE., APT. 212 BALTIMORE, MD 21215 MRS. MIRIAM SHULMAN 9 20e METHOD OF DISPOSITION TO SERVICE A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVICE AND A SERVI 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of must COMITY, CONTROL OF CONTROL 5-1-1995 ISELIN, NEW JERSEY examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY evensor SOL LEVINSON & BROS., INC. n by the f 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, medical upletely filled in by shock, or heart fallure. List only one cause on sech line 6 Interval Between IMMEDIATE CAUSE (Final Onset and Death cremation, disease or condition resulting in death) 1988, MURE 34172320 event. DUE TO OR AS A CONSEQUENCE OF DIVISION OF VITAL RECORDS, P.O. BOX 68760 in and com to burial, o executed as of will Non traumatic CERTIFICATION 178GN Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF if any, leading to immediate requires that the death certificate be een signed by the attending physician of Health and Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease Dr Injury other DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in deeth) LAST 6 PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERF ALITOPSY FINDINGS been signed by the AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? any 1 YES 2 NO shows 1 - YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has be Dept. DR ATTENDING PHYSICIAN: The law 23 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL certificate I HOSPITAL: OTHER 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 N Besidence 8 Other (Specify) 0 the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28d. DESCRIBE HOW INJURY OCCURED 28c. INJURY AT this ( marked. 1 Natural
2 Accident 1 YES 2 NO After ti death BY 28a. PLACE OF INJURY — At homs, farm, strest, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, 90 8 Could not be COMPLETED DIRECTOR: 4 Homicide 28 determined 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, dasth occurred at the time, date and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL
TO THE FUNERAL (
De filed within 72 h
IMPORTANT: If II (Check only one) HOSPITAL 2 ___ MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

MERCY

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29c. LICENSE NUMBER

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29d. DATE SIGNED (Month, Day, Year)

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► 5/1/95

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D. JUAPAULI 31. DATE FILED (Morith, Day, Year)

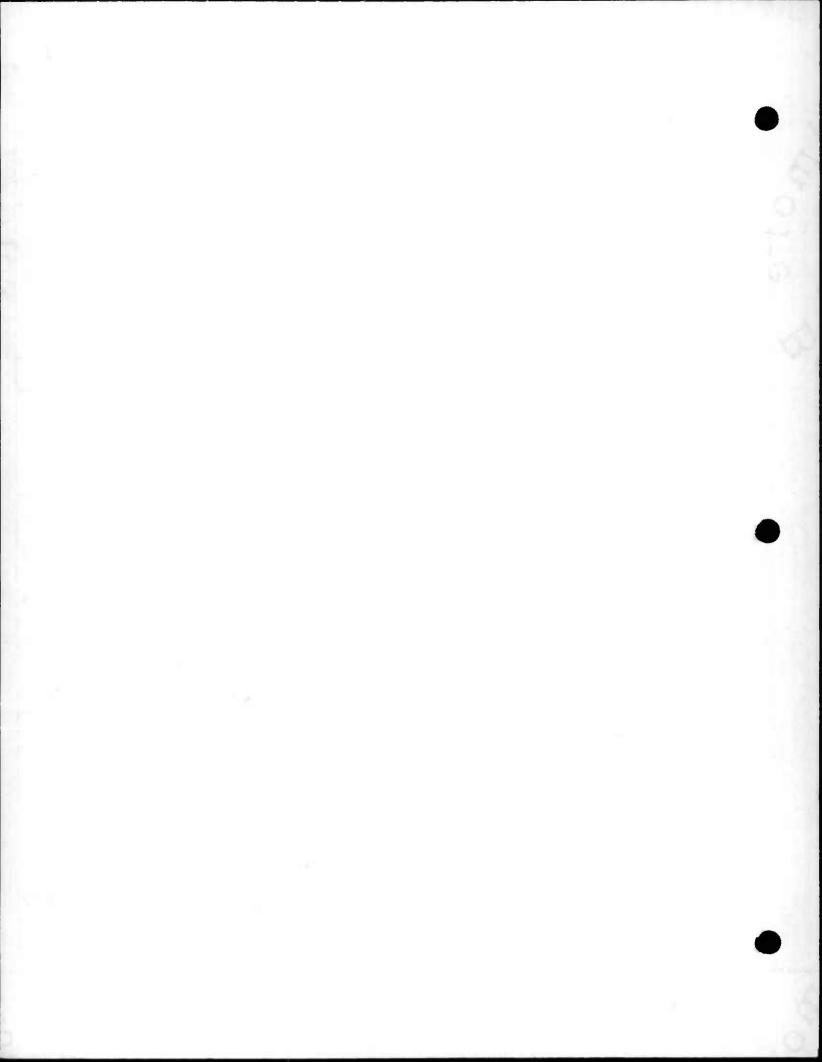
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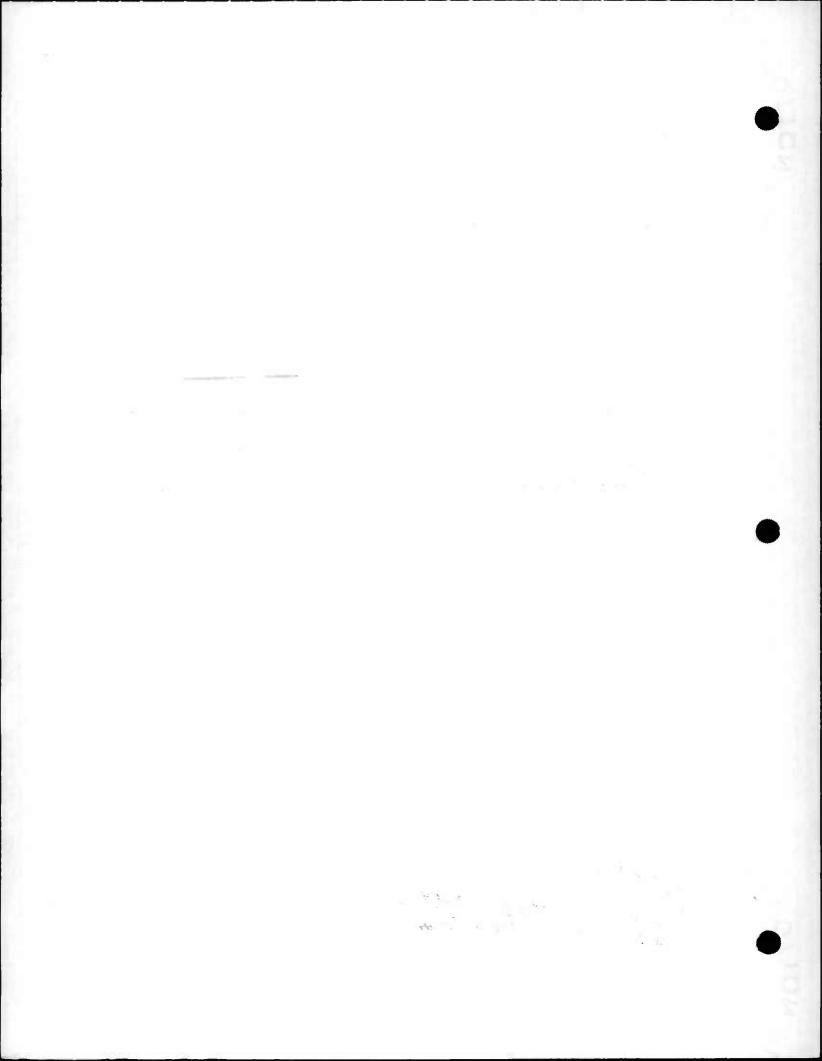
1995

	_	FOR 1 - STATE REGISTRAR	STATE OF MARYLA		NT OF HEALTH AND TE OF DEATH	MENTAL HYGIEN	_			
		1. DECEDENT'S NAME (First, Middle, Last)  RNOLD  F		VERA	IARELLI	2. DATE OF DEATH MONTH DI MAY 01	AY 95 3. ISP M			
7		012 10 2020	5. SEX 6. AGE (In	78 YRS. MONTH	DER 1 YEAR IF UNDER 24 HRS 8 DAYS HOURS MIN.	7. DATE OF BIFTH (Month, Dey, Year)  1ay 29, 19	a Distribut ACC (Contract of Contract			
3 should	000	9a. FACILITY NAME (If not institution, give stre			ITY, TOWN OR LOCATION OF		9c. COUNTY OF DEATH			
ci.	Į,	Good Samaritan Ho	sp. 5601 Loc	k Raven B	altimore					
-0020 ing physician. the burial-transit permit, Pages 1,	DIRECTOR	Maryland 106. COUNTY			n or Location timore		10d. INSIDE CITY LIMITS? 1  YES 2  NO			
an. transit pen	FUNERAL	100. STREET AND NUMBER 6011 Eastern Park			21206		10g. CITIZEN OF WHAT COUNTRY?			
	BY FU	1 Never Married 2 XMarried	12. WAS DECEDENT EVER IN FORCES? 1 ST YES IF YES, GIVE WAR OR DATE Feb. 1941—Ju:	2 NO	I3. WAS DECENDENT OF HISP If yea, specify Cuban, Max 1 ☐ YES 2 NO Spe	ican, Puarto Rican, atc.)	or No- 14. RACE — American Indian, Black, White, atc. Specify: White			
r attend	0	15. DECEDENT'S EDUCA (Specify only highest grade of	TION	16a. DECEDENT'S USUAL	OCCUPATION	16b, KIND OF BUS	SINESS/INDUSTRY			
21 20 al or	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work do life. Do NOT use retire Military			Government			
AN the ho	SO S	17. FATHER'S NAME (First, Middle, Last)				NAME (First, Middle, Maiden				
MARYLAND retained by the hospit should be detached	10	<u>Diodato</u> Vernarel	li				li Porretti			
MAR retained 5 should	TO BE	19a. INFORMANT'S NAME (Type/Print)	1.	1	ESS (Street and Number or Run					
63 00	8	Savannah Vernarel		PLACE AND DATE OF DISP	stern Parkwa					
Page 6 may Il director, pa	E C	1 Buriel 2 Cremetion 3 Remove 4 N Donation 5 Other (Specify)		tery, crematory or other pla		DATE 20c. LO	CATION — City or Town, Stata			
ALTIMORE, death, Page 6 may bi funeral director, page		21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE Ronald W	ade. Dir.	2. NAME AND ADDRESS OF	FACILITY State A	natomy Board			
m - = m	CXS	mous 10	Caro-		655 West Bal	timore St.,	Balto., MD 21201			
urs in t		23. PART I. Entar the diseases, or co shock, or haert failure. Li	mplications that caused is only one cause on asc	the death. Do not an	ar the mode of dying, so	uch as cardiec or reepi	ratory arreet, Approximate Interval Between			
on alle		IMMEDIATE CAUSE (Final					Onset and Dasth			
ted within 24 completely fill (al, cremation,	event,	resulting in death) s.	LOWER	CONSEQUENCE OF:	NTESTINAL	BLEED				
687 ecuted and corr burial,		Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequentially list conditions, Sequen								
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Signed by Health and	MEDICAL	CHRONIC RE	NOC INSU	fficienc	7	1 _ YES 2	COMPLETION OF CALIFE			
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Sicial certific	5  ≿	27. MANNER OF DEATH	Inpetient 2 ER/Outpet	26b, TIME OF	ursing Home 5 Residence	8 ☐ Other (Specify)  28d. DESCRIBE HOW IF	HIDV OCCUPED			
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							ner as stated.  d due to the cause(a) and manner as stated.			
E HOS FUN With	ŭ	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE N		29d. DATE SIGNED (Month, Day, Year)			
TO THE HOSPITAL TO THE FUNERAL De filed within 72	O BE	DTillopally.		MA		238	May 01 95			
~	121	30 NAME AND ADDRESS OF PERSON WHO	COMPLETED OFFICE OF STATE				7,13			

4000 SAMARITAN BARTIMORES MO HOSPITEC 32. REGISTRAR'S SIGNATURE in Randall



		1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF I		MENTAL HYGIEN REG. NO			
		1. DECEDENT'S NAME (First, Middle, Lest) Virginia E. V	isabor				2. DATE OF DEATH DO	AY YEAR	3. TIME OF DEATH	
		4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	5,1995	HPLACE (State or Foreign	
pino		214-12-4904  9e. FACILITY NAME (If not institution, give s	1 □ M 2 X F 7	4 YRS.	MONTHS DAYS	HOURS MIN.	May 27, 1	1920 on	10	
, 2, 3 should	DIRECTOR	SInai Hospita			Control of the control	imore		9c. COUNTY OF I	XEATH .	
Pages 1,	REC	10a. STATE 10b. COUNT			Y, TOWN OR LOCA			10d. INSIDE CITY		
permit. P.		Md. Ba	1timore		undalk			1 TYES 2 THO		
. 5	FUNERAL	2937 Liberty	Parkway		10	2122	2	U.S.A	• WHAT COUNTRY?	
21215-0020 all or attending physician. for use as the burial-transit	BY	11. MARITAL STATUS 1 Never Married 2 M Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	If yes, s	DECIDENT OF HISPA Decify Cuben, Mexic S 2 NO Speci	NIC ORIGIN? (Specify Yes an, Puerto Ricen, etc.) fy:	Yes or No 14. RACE — American Indian, Black, White, atc.  Specify: White		
1215 r attend use as	월	15. OECEDENT'S EOU (Specify only highest grade	CATION completed)	16a. DECEDENT'S (Give kind of	work done during m	ON ost of working	16b. KIND OF BU	SINESS/INOUSTRY		
	COMPLETED	Elementary/Secondary (0-12) 12 yrs	College (1-4 or 5+)	life. Do NOT us	.n Plat		Steel	Compan	nν	
AND the hospital detached fo	NO.	17. FATHER'S NAME (First, Middle, Last)			II I Lac	T	AME (First, Middle, Malden		17	
IARYL should be at at at	BE C	Stephen Nemet	hy			Anne	Berkess		erkes	
5 5 5	2	Paul S. Visch	er				Route Number, City or Tow y . , Dundal		21222	
ALTIMORE, leath. Page 6 may be funeral director, page xaminer must be		20e. METHOD OF DISPOSITION  1) Burlel 2 Cremation 3 Rem	oval from State Cerr	PLACE AND DATE (	ther place)			OCATION — City or To		
Page (		4 Donetion 5 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LIK	DENSEE	altimor	22 NAME A	NO ADDRESS OF E	em . 4-28-9		to.,Md.	
BALTIMO after death, Page 6 by the funeral direct cal examiner mu		+ Eding 4. E	erkins		Brad1	ey-Ash	ton Funer Spring R	al Home	21222 For Md	
B.  Jrs after in by the removal edical		23. PART i. Enter the diseases, or ahock, or heart failure.	complications that caused List only one cause on e	the death. Do r	ot enter the mo	ode of dying, suc	ch ss cardiac or reapi	iratory srrest,	Approximats interval Batween	
760  ed within 24 hours after ompletely filled in by the li, cremation, or remova event, the medical		IMMEDIATE CAUSE (Final disease or condition resulting in death)	though.	Fai	Den E	<b>S</b>			Onset and Daeth	
executed within and completely o burial, cremati natic event, t		10.20.	DUE TO (OR AS A	CONSEQUENCE OF	3: .			0	1	
O. BOX 6870 ertificate be executed ing physician and con griene prior to burial, other traumatic er	NOI	Sequentially list conditions, if sny, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	D:		suc sulcer	111ecs	6 275	
BO)	CAT	csuse. Enter UNDERLYING CAUSE (Disease or Injury	· Menter	5 176 %	NUR	adian			13751	
G 5 10 7 10	CERTIFICATION	that initiated events reaulting in death) LAST	OUE TO (OR AS A	CONSEQUENCE OF):						
Ly, lents dea	- 11	PART II. Other significant condition	s contributing to death b	ut not resulting i	n the underlyin	a cause given in	Part i. 24s. WAS AN	AUTOPSY 241	o, WERE AUTOPSY FINDINGS	
Y and at 70	MEDICAL		trect?				PERFOR	RMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
B C See See		DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YE	S   NO	UNCERTAI	N ET		1 YES 2 NO	
e e e e	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE OF DEAT						
e the cla	14S	1 YES 2 NO	1 ☐ Inpatient 2 ☐ ER/Outp		4 - Nursing Hon	ne 5 🗆 Residence	6 Other (Specify)			
O F S S S	ВУ Р	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	26b. TIMI INJ	URY WO	YES 2 NO	28d. DEŞCRIBE HOW II	NJURY OCCURED		
TTENDI TTENDI TTOR: A after d	ETED B	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, s	treet, fectory, offic	ca .	281. LOCATION (Street a City or Town, State)	and Number or Rural	Route Number,	
4 4 2 E	COMPLE		CIAN: To the best of my knowledge.							
HOSPITAL FUNERAL within 72	- 1	29b. SIGNATURE AND TITLE OF CERTIFIES	R: On the basis of examination	and/or investigatio	n, in my opinion, c					
TO THE HOSPIT TO THE FUNERA be filed within 7	BE C	nel Blue	shows	CMO		DIX.	) <u>73</u>	29d. DATE SIGNED	2 (Month, Day, Year)	
5	5	30. NAME AND ADDRESS OF PERSON WH	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Print)	8620	11: hods	DIAZO	Mallaus	
		31. DATE FILED (Month, Day, Year) MAY 0 4 1995	132 REGISTRAR'S MAN	ATURE	3 (11/2)	Veoc	N. WELL	411114	1101 1 21/3	
	- 11	1000 //								



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S, P.O. BOX 68760,	
US, P.O. BOX 68/60,	
CORDS, P.O. BOX 68760,	irea that the death eartificants he meet that with

DIVISION OF VITAL REC

	1 - STATE REGISTRAR	STATE OF N	MARYLAI	ND / DEPAR CERTIF					MENTAL HYGIEN REG. NO					
	1. DECEDENT'S NAME (First, Middle, Les VERA THELM		S	*					2. DATE OF DEATH D	~2	YEAR 3	G:45P		
	4. SOCIAL SECURITY NUMBER 214 12 9394	5. SEX 1 M 2 TF	6. AGE (In 78	yrs. lest birthday) YRS.	IF UNDER	DAYS	HOURS	24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year) 08 11 16		8. BIRTNPL Country) Ohio	ACE (State or Foreign		
OH	86. FACILITY NAME (If not institution, give street and number)  96. CITY, TOWN OR LOCATION OF DEATH  4207 S. Hunter Road  96. COUNTY OF DEATH  Carroll									тн				
DIRECTOR		10b, COUNTY						CITY, TOWN OR LOCATION 10d. INSIDE						
	100. STREET AND NUMBER 7012 Railway		Dunda		212			10g. CITIZEN OF WHAT COUNT						
TO BE COMPLETED BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	T EVER IN U YES	J.S. ARMED 2 NO ESX		If yes, sp	ENDENT (	OF NISPAN	IC ORIGIN? (Specify Year, Puerto Rican, etc.)	USZ or No—	_			
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)  12  16b. KIND OF BUSINESS/INDUSTRY  16b. KIND OF BUSINESS/INDUSTRY  16b. KIND OF BUSINESS/INDUSTRY  Lever Brothers													
	17. FATNER'S NAME (First, Middle, Malden Surname)  James Mitchell  19a. INFORMANT'S NAME (Type/Print)  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
	Jeannette Winte:	rs		603 D	elaw	are	Ave.		n Burnie,N	1d. 2	1060			
	Burfel 2   Cremation 3   Removel from State   Cematery, crematory or other place													
CATION	23. PART I. Enter the disesses, D shock, or haart failure immediate CAUSE (Final disesse or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	s. DUE TO	tas (OR AS A C	the deeth. Do on the line.  The transfer of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line of the line o	na				Tume		rest,	Approximata Interval Between Onset and Dast G M U N 3 yro.		
CERTIFI	CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):													
AN: MEDICAL	PART II. Other significant conditions contributing to dasth but not resulting in the underlying cause given in Part I.  R + Jernylegia reconstant 1 yes 2 And 1 yes 2 And 1 yes 2 And 1 yes 2 And 24b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 yes 2 And 24b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 yes 2 And 24b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  25b. WAS CASE REFERRED TO MEDICAL									MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
PHYSICIAN:	EXAMINER?  1 VES 2 D NO  27, MANNER OF DEATH  1 Matural 5 Pending	HOSPITAL: 1 Inpatient 2 28e. DATE OF (Month, D.	INJURY	28b. TIN		R: sing Nom 28c. INJ WO	• 5 DA	eldence	8 Other (Specify) 26d. DESCRIBE HOW	INJURY OC	CURED			
TED BY	2 Accident Investigation 3 Suicide 6 Could not b 4 Nomicide determined	28e. PLACE O	F INJURY — etc. (Specify	At home, farm,				_ NO	281. LOCATION (Street City or Town, State)		r or Rural Rou	ite Number,		
COMPLET	opel -								to the cause(s) and ma			and menner se stated.		
8	296. SIGNATURE AND TITLE OF CERTIF	enoard	M	P			29c. LIC	ENSE NUM	2386		5-2	Honth, Day, Year) - 1995		
2	30. NAME AND ADDRESS OF PERSON V	MD COMPLETED CAUS	3 a	H (ITEM 27) (Type	AIN	,51	4	MA	Nches	ter	Md	21102		
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30. NAME AND ACORESS OF BERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Simon V. Schia A. 2000 E

31. DATE FILED (Month, Day, Year)

MAY 0 5 1995 July 34 REGISTBAR ROWATH

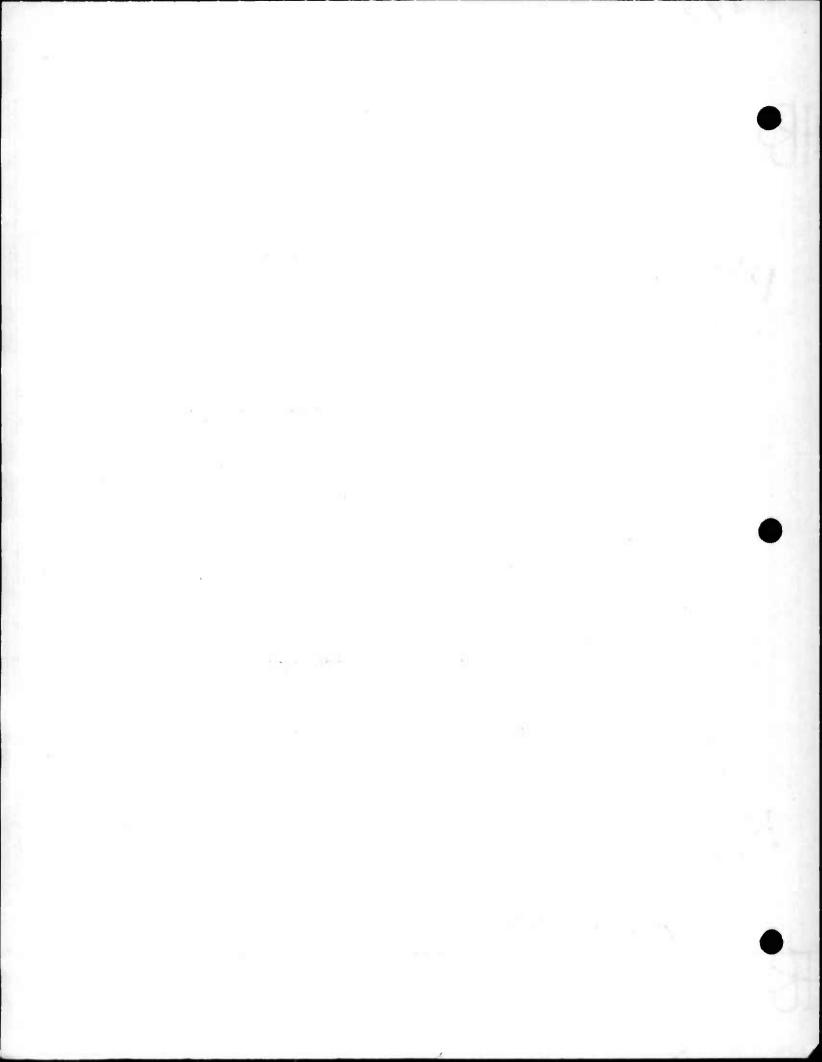
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

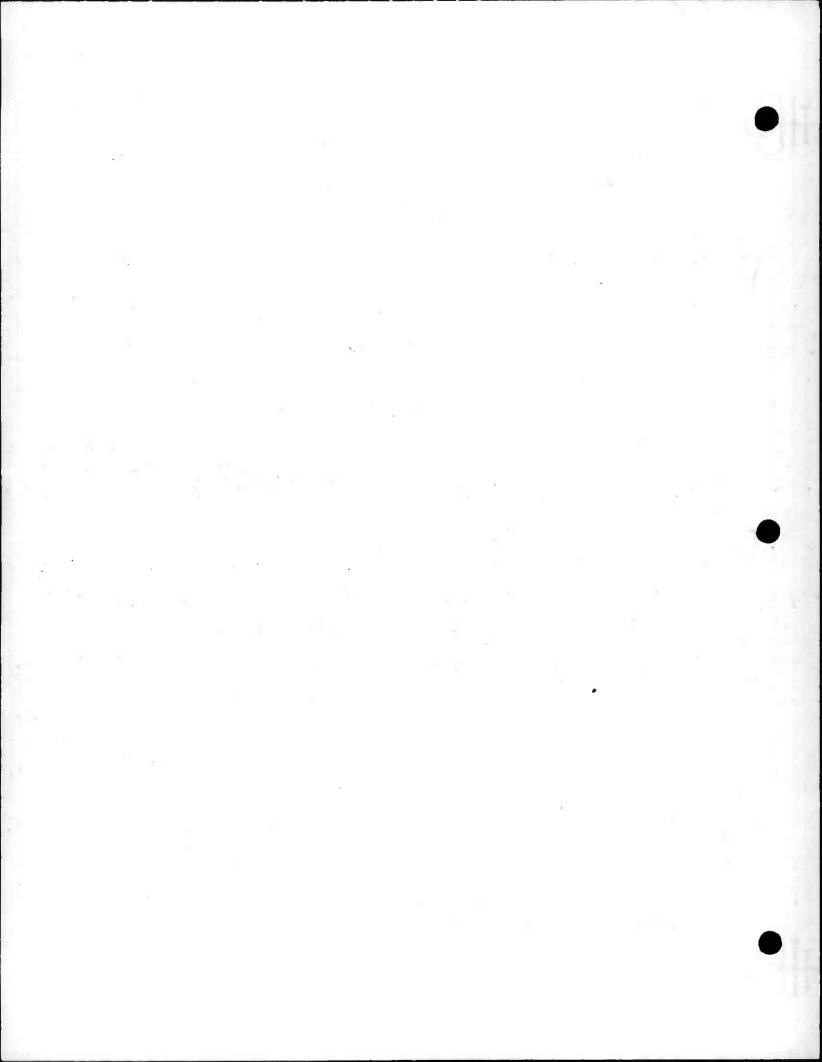
											9	5	13399
		FOR 1 STATE	STATE OF MAR	RYLAND /	DEPAR	TMENT	OF H	EALTH	AND N	MENTAL HYGIEN	E		
		REGISTRAR  1. DECEDENT'S NAME (First, Middle, Last)		CE	HIIF	ICATE	OF	DEA	TH	REG. NO			
		AT DEEM	ממ אוזעוו							2. DATE OF DEATH DO	3. TIME OF DEATH		
	1 1	. 13	VKWARD							May 1	, 199		5:15 P M
		010 01 4400		AGE (In yrs. lest		IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHI Country	PLACE (State or Foreign
			X)(M 2 □ F	04	YRS.	All Control		1 11 2 11	17.2341		911	Mar	vland
	~	9a. FACILITY NAME (If not institution, give stree	t and number)						ON OF DE	ATH	9c. COU	NTY OF DE	
	ECTOR	4700 Harford Road				Balt	imor	:e				n	/a
	E C	10a. STATE 10b. COUNTY			10c. CIT	Y. TOWN O	B I OCATI	ION					and moves over
	DIR	MD	n/a			altim		1011					10d. INSIDE CITY LIMITS?
	AL C	10e. STREET AND NUMBER			Do	TLLI		ZIP CODE			Transport		1 X YES 2 NO
- 1	-	4700 Harford Road					101.		1214				HAT COUNTRY?
	UNE	11. MARITAL STATUS	2. WAS DECEDENT EV	ED IN ILC. ADA	450	1 40 1						J.S.A	
	工	1 Never Married 2 Married	FORCES? 1	YES 2 X N	O O	13. 1	NAS DECE I yes, spe	elfy Cuba	of HISPAN n, Maxicar	IC ORIGIN? (Specify Yes	or No-	Black,	- American Indian, White, atc.
	ВУ	3 XWidowed 4 Divorced	IF YES, GIVE WAR	OR DATES		1	YES	2 X NO	Specify	•	- 1	Specif	Black
	ED	15. DECEDENT'S EDUCAT	ION	16a, DEC	EDENT'S	USUAL OC	CLIPATIO	M		16b. KINO OF BU	elvicee (win		
	E	(Specify only highest grade col		(Gh	w kind of a Do NOT us	vork done a	luring mos	t of working	ng	TOO. KING OF BO.	3/11/2-3/11/10	OSINI	
	7	11th	College (1-4 or 5 +)	I T.a	abore	or				Steel	Indus	strv	
once.	COMPL	17. FATHER'S NAME (First, Middle, Last)		1 100	IDOL			18 MOTA	HER'S NAI	ME (First, Middle, Maiden		JCL Y	
=	Ü	Elijah Awkward								ia Turner	Surneme)		
	00	19a. INFORMANT'S NAME (Type/Print)		106	MAUINO	ADDRESS	/01				-		
notified	임	19a. INFORMANT'S NAME (Type/Print)  Deborah Thomas  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  1211 Silverthorne RD/Baltimore, MD 21239											
pe		204, METHOD OF DISPOSITION		20b. PLACE A					- 10/				
must		1 🖾 Burlat 2 🗆 Cremation 3 🗆 Ramova 4 🗆 Donation 5 🗆 Other (Specify)	it from State	MARYL	WASALE O	ther placet	T O N A		CMET		CATION —	*	
10		21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE /	MARTL	AND					ERY5-6 LAL		MAK	YLANU
examiner		. ~	Ve			Ma	rch	Fune	eral	Home East			
- X		1-ronce	2//	Les &	_	111	Ol E	E. No	orth	Avenue/Ba	ltimo	re,	MD 21202
medicai		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											Approximate
E		ahock, or heart failure. List only one cause on each line.										Onset and Daath	
=		disease or condition											
Vent	DUE TO (OR AS A CONSEQUENCE OF):												<u> </u>
or other traumatic event, the	2	-	Ancestia									1	
E	ERTIFICATION	Sequentially list conditions,  If any, leading to immediate  b. DUENTO (OR AS A CONSEQUENCE OF):											
直	8	cause. Enter UNDERLYING	Stro	V.E									
the	Ē	CAUSE (Disease or Injury that initiated events		AS A CONSECU	JENCE OF	7:							
0	토	resulting in death) LAST	DRIBA	iosda	ti	V	411	lac	. De	157			
2	2												
를 기를	DICAL	PART II. Other algnificant conditions of	contributing to dea	th but not re	aulting I	n the un	derlying	cause g	lven in I	Part I. 24a, WAS AN PERFOR			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
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23 sh	2.0	DID TOBACCO USE CONTRIE	BUTE TO CAUS	E OF DEAT	H YE	S   N	10 🗆	UNC	ERTAIN				
item 2	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE	OF DEAT	H (Check o	nly one)						
or ite	Sic	4 CT same in State of	OSPITAL:	Outpatient 3	DOA	OTHER		5 🗆 Re	aldence (	B ☐ Other (Specify)			
	РНҮ	27. MANNER OF DEATH	28a. OATE OF INJU		26b. TIM	E OF	28c. INJU	RY AT		28d. OESCRIBE HOW II	NJURY OCC	URED	
marked	BY F	1 Netural 5 Pending	(Month, Day, Ye	Helf)	INJ	URY M	1 Y		NO				
E	0 8	2 Accident Investigation 3 Suicide 8 Could not be	26a. PLACE OF IN.	JURY — At hom	ie, term, e	treet, facto	ry, offica		$\rightarrow$	28f. LOCATION (Street a	and Number	or Rural Ro	oute Number,
28	ETEC	4 Homicide determined	building, atc.	эреспу)						City or Town, State)			
Hem	PE	29a. CERTIFIER	N. Ta tha hard of a co				7 7 mm		11111111	= -27			
=	Ā									to the cause(a) and man			RATE CONTRACTOR
ANT	COM		A SAME			, my op	ликоп, <b>00</b>	etti becun	ed at the t	mme, cets and place, an	a due to th	o cause(a)	and manner as stated.
IMPORTANT	BE	29b. SIGNATURE AND TITLE OF CERTIFIER	1					29C. LICE	NSE NUM	7	29d. DATE	SIGNED (	(Month, Day, Year)
IMP	0	0	0					UL	427	6	1	4.21	
- 1	- 0	30. NAME AND ADDRESS OF PERSON WHO C	OMBLETES SAUSE OF										

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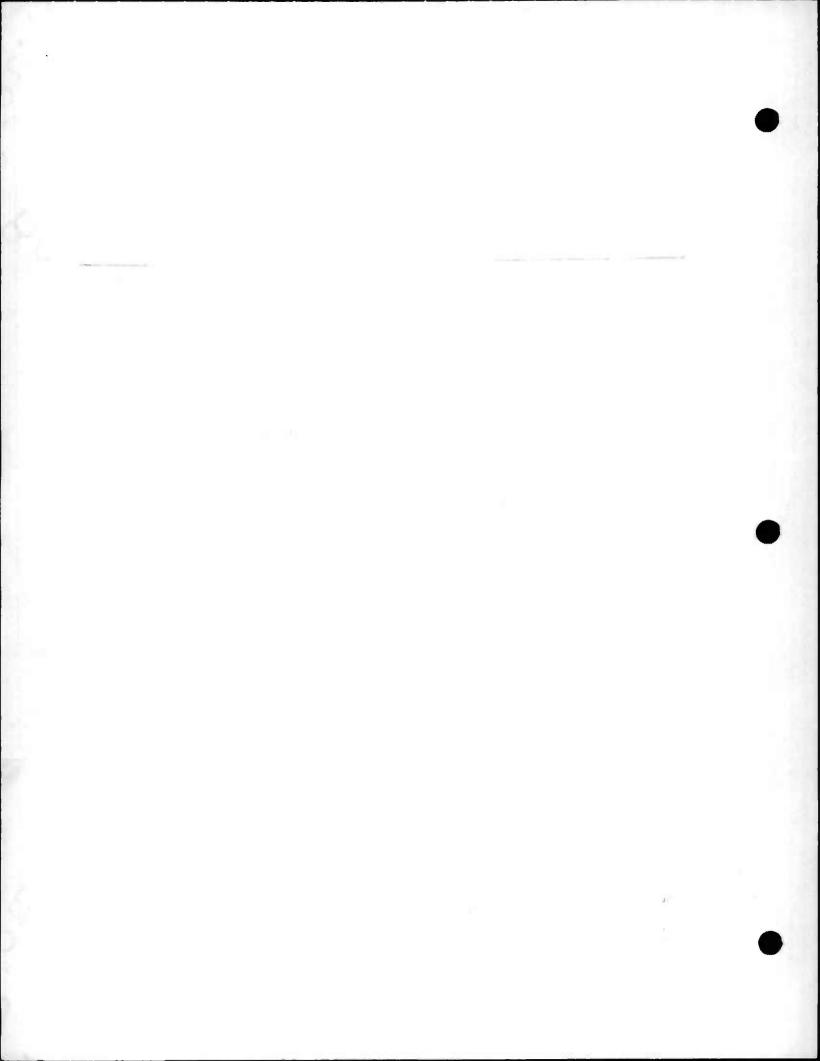


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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY 3. TIME OF DEATH YEAR Catherine Atkins 1995 2:45P. May 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 6. BIRTHPLACE (State or Foreign Country) DAYS HOURS 1 | M 2 | X F 216-16-3782 5/29/22 MARYLAND Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 1831 DARRICH DRIVE TOWSON BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE TOWSON permit. 1 YES 2 X NO FUNERAL 10e STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 1831 DARRICH DRIVE 21234 USA death. Page 6 may be retained by the hospital or attending physician, 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 YNO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried IF YES, GIVE WAR OR DATES 1 TYES 2 XNO Specify: WHITE BY Specify 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION ecily only highest grade complet 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER 12th GRADE OWN HOME once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) 7 FRANK K. COFFIN BE ANNA M. BOSCH notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1831 DARRICH DRIVE EAR. J. ATKINS TOWSON, MD 21234 pe 20e. METHOO OF DISPOSITION
1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State must 20b. PLACE AND OATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State PARKWOOD CEMETERY 4 Donation 5 Other (Specify) _ 5/4/95 BALTIMORE, MARYLAND examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
The Johnson Funeral Home 8521 Loch Raven hustin Blvd. Towson, Md. 21286 the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. filled in by **Approximate** 5 Interval Between IMMEDIATE CAUSE (Final **Onest and Death** cremation, disease or condition_ signed by the attending physician and completely Health and Mental Hygiene prior to burial, crematis resulting in death) event, CHRONIC OBSTRUCTIVE DISEASE YEAR STAGE traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING SCLEROSIS MULTIPLE eas CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST 0 1000 injury. PART II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO shows 1 TYES 2 TO NO been it. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO IX UNCERTAIN I has b. Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h Item HOSPITAL: ATTENDING PHYSICIAN: 1 TES 2 NO 1 - Inpatient 2 - ER/Outpatie 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 6 the 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED this marked, 1 Natural 5 Pending 1 YES 2 NO ВУ death 2 Accident 3 Suicide 28e. PLACE OF INJURY --- At home, farm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) .00 COMPLETED a Could not be DIRECTOR: / 4 Homicide 28 tem OR 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. TO THE HOSPITAL O
TO THE FUNERAL D
De filed within 72 ho
IMPORTANT: If 18 2 MEDICAL EXAMINER: On the basia of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner ea stated. 296. SIGNATURE AND FITLE OF CERT 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, BE val 95 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 505-OSLER M.D. O'DEA MEDICAL 501 -



		1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEAL CERTIFICATE OF DE	LTH AND MEN	TAL HYGIENE REG. NO.	
		1. DECEDENT'S NAME (First, Middle, Last)		ATE OF DEATH	3. TIME OF DEATH
		STEPHEN M. BROOKS			995 1:00 P M
		MONTHS DAYS HOU	URS MIN. (A	ATE OF BIRTH forith, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
pinous		217-88-6213 VAM 2 F 18 VRS. MONTHS DAYS HOU  98. FACILITY NAME (If not institution, give street and number)  99. FACILITY NAME (If not institution, give street and number)		)-15-76	Maryland
1, 2, 3	CTOR	THE JOHNS HOPKINS HOSPITAL BALTIMORE		ac.	COUNTY OF PEATH
Pages	DIREC	10a, STATE 10b, COUNTY 10c, CITY, TOWN OR LOCATION			10d. INSIDE CITY LIMITS?
permit, P.		Maryland X A Baltimore			XM YES 2 □ NO
	ERAL	104. STREET AND NUMBER 5341 JAMESTOWN CT.	COOE	109	CITIZEN OF WHAT COUNTRY?
020 physician. burial-transit	FUNE	4708 Edmondson Ave:  11. MARITAL STATUS  12. WAS DECEDENT EVER IN U.S. ARMED  13. WAS DECEDENT.	2/20	7	~America USA
		1 Never Married 2 Married   FORCES? 1 TES 2 XNO   If yes, specify C	ENT OF HISPANIC OR Cuban, Maxican, Pue NO Specify:	IGIN? (Specify Yea or No rto Rican, etc.)	Black, White, atc.
5-0 nding is the	BY	3 Widowed 4 Divorced	NO Specify:		Specify: Black
r afte	TED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of w	working	16b. KIND OF BUSINES	
	PLET	Elementary/Secondary (0-12)  12  College (1-4 or 5+)  Student		0.1	
AND 2 he hospital detached fo	COMPL			Jeno6L	
# 8 4			oris Ho	rst, Middle, Melden Surne. rshaw	me)
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5 5 5	2	Doris Brooks 5341 Jamestown	n Ct. Ba	alto., Mo	ne, Zip Code)
L S E		20a, METHOD OF DISPOSITION 20h PLACE AND DATE OF DISPOSITION (Name of	and Maria	200 1004710	N — City or Town, State
D 6 5 5		1 & Burtal 2 Cremetton 3 Removal from State 4 Donestion 6 Other (Specify)	Modition 5	2 5000	1 2
AL I IM death. Page funeral dire		21. SIGNATURE OF FUNERAL SERVICE LICENSEL 22. NAME AND ADD	DORESS OF FACILITY		lawn, Md.
ALTIN death. Pag tuneral di tuneral di examiner				ghts Ave.	
y the		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of	k Jones	Funeral	Home Approximate
T of to		shock, or heart failurs. List only one cause on each line.	n dynny, and ac.	Alumo or respirator.	interval Batween Onset and Death
= =		disease or condition resulting in death)  . (a calac tam panade (	12000	(dico)	34/5
ompletel d. crema		DUE TO (OR AS A CONSEQUENCE OF	Series	ru iac.)	
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OX 68 e be execut sician and c rior to burit traumatic	Ĕ	if any, leading to immediate cause. Enter UNDERLYING			1 101
certificate ding physic tygiene pri	윤		Konia		lyr-10mps
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Siclan Certific the S	PHYS	1 U YES 2 NO Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 27. MANNER OF DEATH 28s. DATE OF INJURY 26s. TIME OF 26c. INJURY A			
NG PHYS frer this ceath with marked,		1 Netural 6 Pending (Month, Day, Year) INJURY WORK?	2 NO 26d.	DESCRIBE HOW INJURY	/ OCCURED
VDING Ster death	ВУ	2 Accident Investigation 288 PLACE OF IN HIDY At home form dead feature at large	$\overline{}$	OCATION (Street and No.	mber or Rural Route Number
OR ATTENDING DIRECTOR: Atter hours after death item 28 is ma	E	4 Homleide determined building, atc. (Specify)		ity or Town, State)	invel of nurel noute number,
E 6 8 9 5	LET	29a. CERTIFIER	artinicata		
14 25 日	COMPL	(Check only one)  2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and pi			
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If	11	SOL CONTACTOR AND STREET OF ASSESSED			The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s
불물을	BE	GINVEG MD/ Dove	LICENSE NUMBER	29d.	DATE SIGNED (Month, Day, Year)
263	임	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)	1146149		-(158/92
5		losses of Die II II II II and an	M GAAN	116 51	R. H. 2128741
$\bigcirc$		31. DATE FILED (Month, Day, Year) 4 32. REGISTRAR'S SIGNATURE	N GUO N.	Wolfe St	KIN MININD
		MAY 0 5 1995 July Devaler Redell			



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29b. SIGNATURE

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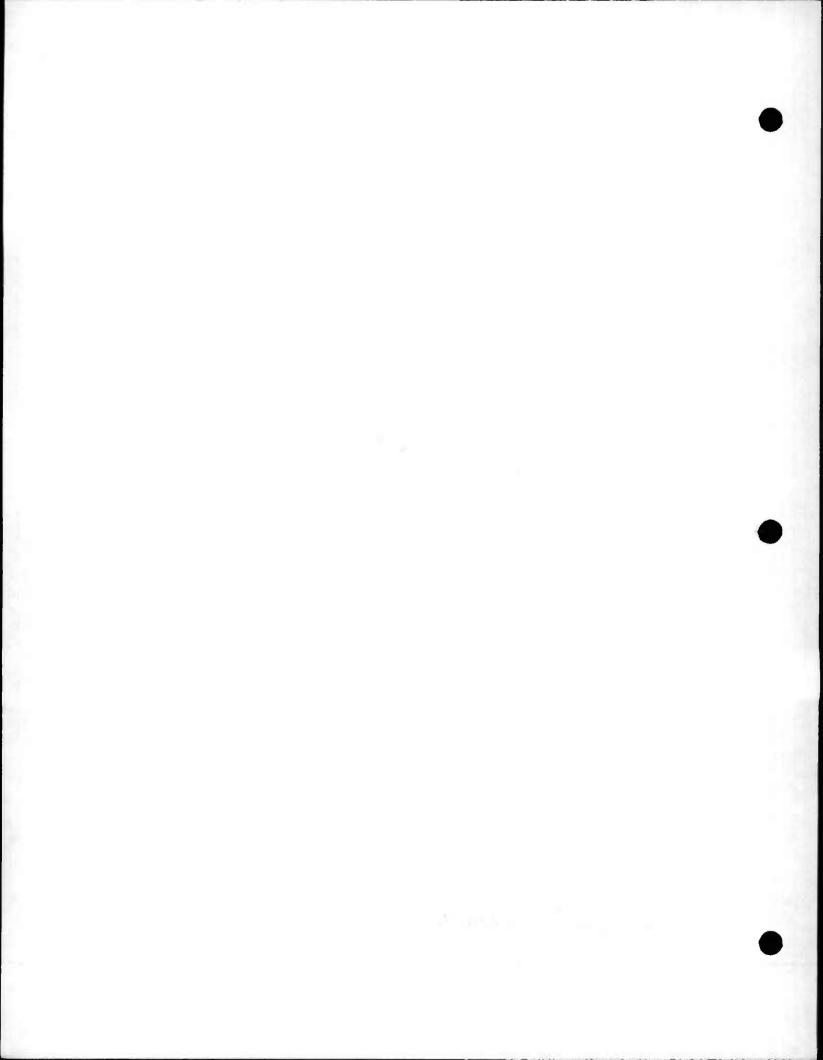
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH April Blinke 1993 Lawrence R. 3:00 P 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR 6. BIRTHPLACE (State or Foreign DAYS 1 M 2 - F 212-20-3008 71 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF OFATH 9c. COUNTY OF DEATN DIRECTOR Birdale Ave 13223 Baltimore. Baltimore. RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore Maruland Baltimore. 1 YES 2 NO been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. of Health and Mental Hygiene prior to burial, cremation, or removal. FUNERAL 10a STREET AND MIMBER 10f. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? 13223 Birdale Ave 21220 U.S.A. executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES X O'NCAN WW II, Conflict 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuban, Mexican, Puerto Ricen, atc.) 14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married 1 YES 2 NO BY Specify: 3 Wildowed 4 Olyorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY entary/Secondary (0-12) College (1-4 or 5+) 12th Laboror Brewery 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Malden Surname) notified at BE David Blinke. Anna Louise Cademore 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Dorothu Sontz Sylvan Ave Baltimore Maryland 21220 13126 pe METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must Buriel 2 Cremetion 3 Removat from State

Donation 5 Other (Specify) Woodlawn Cemetery Baltimore Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home. Inc. 9705 Belair Rd. Baltimore, Maryland 21236 the medical 23. PART | Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, ahock, or heert feliure. List only one cause on each line Interval Batween **IMMEDIATE CAUSE (Finel** Onset and Death disesse or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) event, amoriones adama traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST ŏ PART II. Other significent conditione contributing to deeth but not recuiting in the underlying ceuse given in Part i. PHYSICIAN: MEDICAL 24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY shows any 1 YES 2 NO OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN | has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only or After this certificate death with the State HOSPITAL OTHER 1 TES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) ö 27. MANNER OF DEATH 28e. OATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED Natural 5 Pending 1 YES 2 NO BY 2 Accident ATTENDING 28e. PLACE OF INJURY — At home, farm, atreet, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 99 COMPLETED 6 Could not be DIRECTOR: 4 Nomicide 28 8 29e. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE BE filed within 72 h

NRO474 MIQ COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) 2/20 MAY 0

2 __ MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and placa, end due to the ceuse(s) and manner es stated.

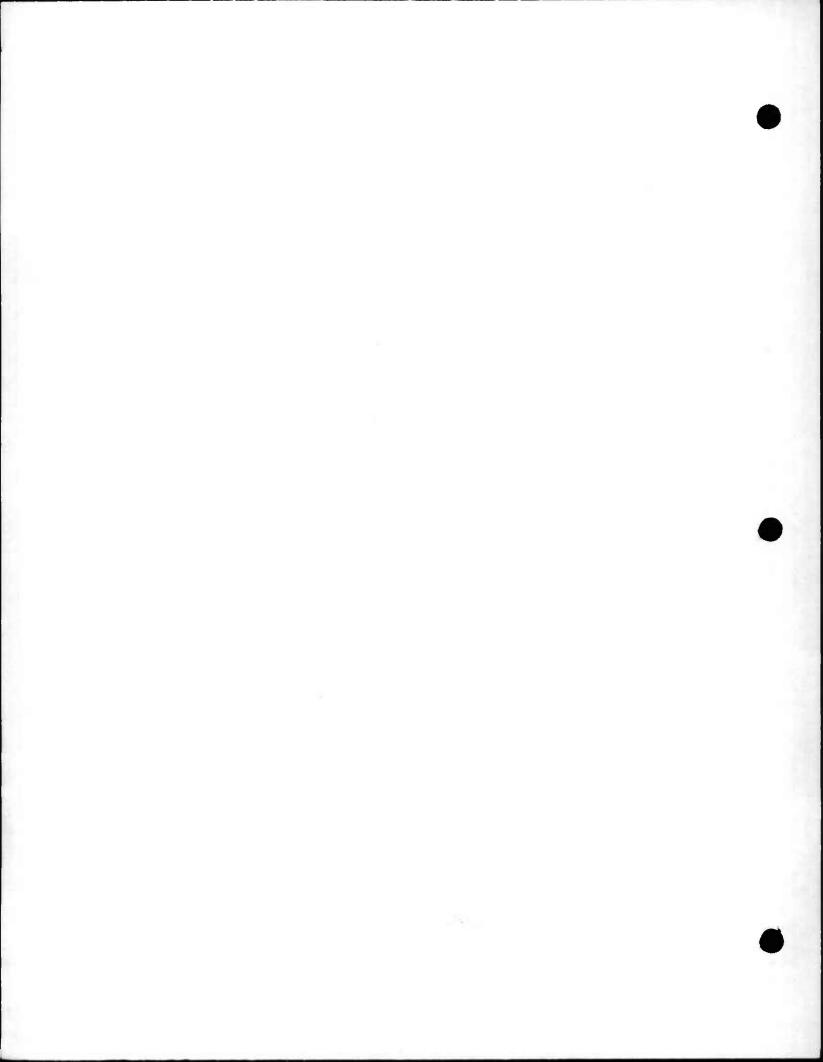
29d. DATE SIGNED (Month, Day, Year)



DIVISION OF VITAL RECORDS. P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEOENT'S NAME (First HELEN	BOAK								2. DATE OF E	DEATH DA	1995	YEAR	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In y	rs. lest birthdey)	IF UNDER	1 YEAR	IF UNDER	R 24 HRS.	7. DATE OF E		1995		9:10 p. M
-		216-10-8449	)	1 🗆 M 2 💢 F	81	YRS.	MONTHS	DAYS	HOURS	MIN.	April	ny Wanzi	1914	Country	yland
2, 3 should		9e. FACILITY NAME (If not in							OR LOCATI	ION OF DI		,		NTY OF DE	2
	ECTOR	Camden Yara		silitatio	on Cent	ter	Bal	etim	ore				N/A		
Pages 1,	ا ش ا	10e. STATE	10b. COUNTY	Y		10c. Cr	TY, TOWN	OR LOCA	TION						10d. INSIDE CITY
nt. Pa	DIR	Maryland	N/A			Ва	ltimo	ire						_	LIMITS?
if permit.	FUNERAL	3812 Hamilt		2:44.0					H. ZIP CODE					CITIZEN OF WHAT COUNTRY?	
DAO physician. burial-transit	JNE	11, MARITAL STATUS	JON AUE	12. WAS DECEDEN	NT EVER IN U.S	e ADMED	21206  ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN?							S.A.	
MARY ILAND ZIZIS-0020 retained by the hospital or attending physician 5 should be detached for use as the burial-train outlifled at once.		1 Never Married 2		FORCES? 1	1 YES 2	2 X NO		if yes, sp	pecify Cuba S 2 X NO	an, Maxica	en, Puerto Ricar	n, stc.)	or No—	14. RACE Black Specif	— American Indian, i, White, aic.
ending as the	ED BY	3 Widowed 4 Divo												Open	" White
or after	ETE	(Specify only	CEDENT'S EDU	completed)		(Give kind of life. Do NOT u	work done	CCUPATIO	ON ost of working	ing	16b, KIN	ID OF BUS	INESS/IND	USTRY	
hospital iched fo	APL	9th grade	)-12)	College (1-4 or 5	+)	Steam		5 0	pera	tor		Text	tile	Comp	anu
the hospit detached		17. FATHER'S NAME (First, M							16. MOTA	HER'S NA	AME (First, Middle		_		
ed by a	BE (	Abraham Gershowitz Lena Kraus													
be retained to 5 should a notified	10	Leonard M.		(Son)		3101	St.	Pau	end Number	r or Rural I	Poute Number, Copt. 4,		n. State, Zip Etimo		Md. 21218
e 6 may be ector, page t		20a. METHOD OF OISPOSITION 1.A. Burial 2 Cremation 4 Donation 5 Other	on 3 🗆 Rame	oval from State		ACE AND DATE				5			cation - c		wn, Stota Maryland
		21. SIGNATURE OF FUNERAL		ENSEE /	0 /	Λ	22.	NAME AP	ND ADDRES	ESS OF FA	CILITY		Mino.	re,	Margrana
0 7 0		Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Md. 21213  23. PART I. Enter the disease, or complications that causes the death. Do not antar the mode of dying, such as cardiac or respiratory arrest,  Approximate										. 21213			
ed within 24 hours completely filled in al, cremation, or n	Z	anock, or na	interval Between Onset and Daath  Candra Duronom award  Due to (or as a consequence or):  Candra Duronom award  Due to (or as a consequence or):												
sician a	CATION	Sequentially list conditi if sny, leading to immed cause. Enter UNDERLY	diata ING	Due to	OR AS A CON	HSTOUENCE C	)F):	9	100	Co	se	-			
h certificat inding phys Hygiene p	RTIFIC	CAUSE (Disease or Inju that initiated events resulting in death) LAS		DUE TO	O (OR AS A CON	1	1			-		00	- 4 .		
	씽	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS													
that the dea led by the att th and Menta any Injury,	EDICAL	PART II. Other algoritica	nt condition	a contributing to	death but n	ot resulting	In the un	derlying	g cause ç	given in	Part I. 24a.	PERFORM		-	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
signed Health a	EDI								-		10	YES 2	DNO		OMPLETION OF CAUSE OF DEATH?
w requires been sign x. of Heall	Σ	DID TOBACCO U	ISE CONTI	RIBUTE TO CA	AUSE OF D	DEATH Y	FS 🗆 I	NO R	LINC	FRTAII	N [				1 TES 2 NO
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CIAN: 1 artificate the Stat	YSIC	1 TYES 2 NO		HOSPITAL:	☐ ER/Outpation	M 3 DOA	OTHER 4 W Num		10 5 🗆 Ra	asidence	8 - Other (Spe	ecify)			
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OTTENDI OTOR: A after de	TED B	3 Suicide 6	Could not be determined	26a. PLACE O building,	OF INJURY — A	it home, farm,	streel, fact	ory, office	•		281. LOCATION City or Tox	N (Street an wn, State)	nd Number o	or Rural Ro	oute Number,
DIRIU Pour	COMPLE			CIAN: To the best of											
HOSPITAL FUNERAL Within 72	CON				xamination and	f/or investigation	on, In my o	pinion, d	eath occur	red at the	lime, data and	place, and	dua lo lhe	cause(s)	and manner as stated.
표 분을 중	BE (	296. SIGNATURE AND TITLE	OF CERTIFIER	1 60	1	-1			29c. LICE	ENSE NUM	MBER 6		29d. DATE	SIGNED (	(Month, Day, Year)
₽ ₽ % ₹	2	30. NAME AND ADDRESS OF	F PERSON WH	O COMPLETED CAU	ISE OF DEATH	(ITEM 27) (TVD)	Print)		DIX	14	X Y		- 3	5)4	195
1		H. TAV	ASS	OLIE	MD	3	45.	5 4	uil	1212	ES B	UE I	+ +	30 MA	621229
8		MAY 0 5	995 J	and district		34									,



TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing a first float. Page 5 may be retained by the historians that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

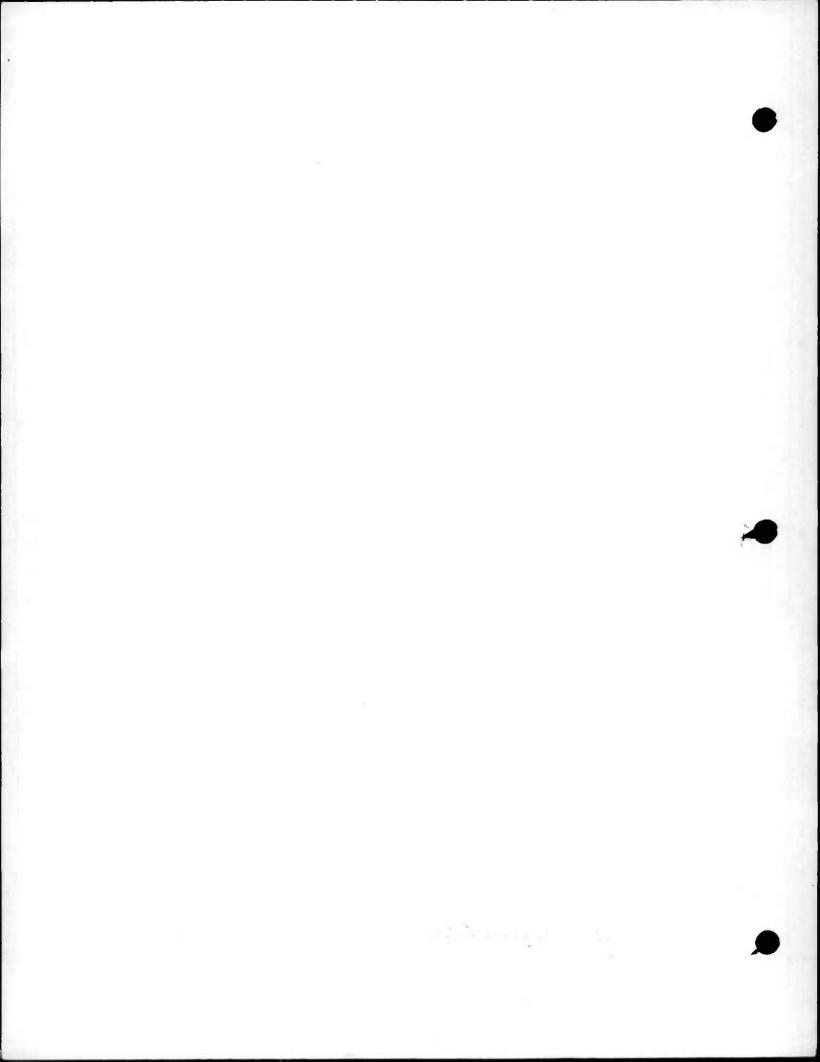
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTMENT (		MENTAI	L HYGIENE REG. NO.					
ž	1. DECEDENT'S NAME (First, Middle, Last)		0.2.		2. DATE	OF DEATH	YEA	3. TIME OF DEATH			
	RODNEY  4. SOCIAL SECURITY NUMBER	5. SEX	BLAC		MA	y 3	1995	12115PH			
	213-64-5080	1 M 2 □ F	yrs. last birthday) IF UNDER 1 Y 4 O YRS. MONTHS D	EAR IF UNDER 24 HRS. AYB HOURS MIN.	OCT	OF BIRTH	4 18	ATV and			
OB	8. FACILITY NAME (If not institution, gips st	dical G	enter Ba	TIMO	DEATH		ec. COUNTY O	DEATH			
DIRECTOR	100 STATE 10b. COUNTY	11/10	10c. CLEY, TOWN OR I	OCATION				10d. INSIDE CITY			
	VARVIAND NIMBER 100. STREET AND NUMBER 100. CITIZEN							1 YES 2 NO			
FUNERAL	2902 W. Cola	U U	S A								
	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVEN IN FORCES? 1 YES	2 NO If yo	is, specify Culien, Mexic	cen, Puerto F						
ED BY	3 Widowed 4 Divorced		16a. DECEDENT'S USUAL OCCU	YES 2 NO Spec			Black				
	15. DECEDENT'S EDUC (Specify only highest grade Elementers/Secondary (0-12)	Υ									
COMPLET	12	College (1-4 or 5+)	COOK		_	<u>Kest</u>	dur	ant			
8	17. FATHER'S NAME (First, Middle, Lest)	nek		18. MOTHER'S N	AME (FISI, A	Middle, Maiden Su	rneme)				
BE	190. INFORMANT'S NAME (Typo/Pdat)	acr	196. MAILING ADDRESS (S	reat and Number or Bura	I Route Numb	ber City or Town	NED State Zira Code	5			
2	Loretta Blo	cK	2902 W.	Coldspr	ring	Lane	PT.B	alto, Md.21215			
	20e. METHOD OF DISPOSITION  1 M Burlet 2 Cremetton 3 Remo 4 Donatton 5 Other (Specify)	oval from State 20b.1	alloading and Free April 6 course	N (Name of	5/8/	35 / 11Y	TION - Gity or	Town, State			
	21. SIGNATURE OF FUNERAL SERVICE/LIC	ENSEE O D	22. NAI	AE AND ADDRESS OF	ACILITY	c E	0001	Hame			
	* Joseph	L. Ru	122	22 W. N.	rtic	Ave	Ball	Md.2/2/6			
	23. PART V Enter the dispuses, or c shock, or heart failure. I	omplications that caused List only one cause on ea	the death. Do not anter the ch line.	moda of dying, su	ch as card	liac or respira	lory arrest,	Approximate Interval Between			
	IMMEDIATE CAUSE (Final disease or condition	<i>a</i> = .	24.7					Onset and Death			
	resulting in desth)  a. SEPSIS  DUE TO (OR AS A CONSEQUENCE OF):										
NO	Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF):										
ATI	If any, lasding to immediata cause. Entar UNDERLYING	DUE TO (OH AS A C	CONSEQUENCE OF):								
F	CAUSE (Disease or Injury that initiated eventa	DUE TO (OR AS A	CONSEQUENCE OF):								
CERTIFICATION	resulting in death) LAST	ı									
CALC	PART II. Other significant conditions	contributing to dasth bu	t not resulting in the unda	lying cause given in	n Part I.	24s. WAS AN AU PERFORME		24b. WERE AUTOPSY FINDINGS			
DIC						1 TYES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
PHYSICIAN: MEDI	DID TORACCO LISE CONTE	UDUITE TO CAUCE OF	BEATH VEC D NO					1   YES 2   NO			
AN	DID TOBACCO USE CONTR		6. PLACE OF DEATH (Check only								
SIC	EXAMINER?	HOSPITAL: 1   Inputient 2   ER/Output	tient 3 DOA 4 Nursing	Home 5 ☐ Reeldence	6 🗆 Other	r (Specify)					
E	27, MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Yeer)	28b. TIME OF 18b. INJURY	:, INJURY AT WORK?	26d. DE\$	CRIBE HOW INJ	JRY OCCURED				
B	1 🕅 Natural 5 🗌 Pending 2 🔲 Accident Investigation	260 BLACE OF IN HIDY	M 1  — At home, ferm, street, factory,	YES 2 NO							
TED	3 Suicide 8 Could not be 4 Homicide determined	building, atc. (Specify	— At nome, ferm, errest, tactory.	отнее	City o	ATION (Street end or Town, State)	Number or Hur	al Route Number,			
COMPLETED				occurred at the time, date end place, end due							
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) at											
296. SIGNATURE AND TITLE OF CERTIFIER  296. LICENSE NUMBER  296. LICENSE NUMBER  D 23300  5-3-6  30. NAME AND ADDRESS OF PERSON WIND COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  LIBERTY Mechicari Caulty  SUDMIR. D, PATEL. 2600 dilinity Yuighia. Bollo. M  31. DATE FILED (Month, Day, Viser)  MAY 0 5 1995						ED (Month, Day, Year)					
임	30. NAME AND ADDRESS OF PERSON WNO	COMPLETED CAUSE OF DEAT	TH (ITEM 27) (Type, Print)	berry M	echie	ort Co	ultr				
	SUDHIR . D.	PATEL.	2600 dil	inty M.	eigh	12. G	Bollo.	MD, 21215			
	MAY 0 5 1995	A DESTRUCTION	KELL								

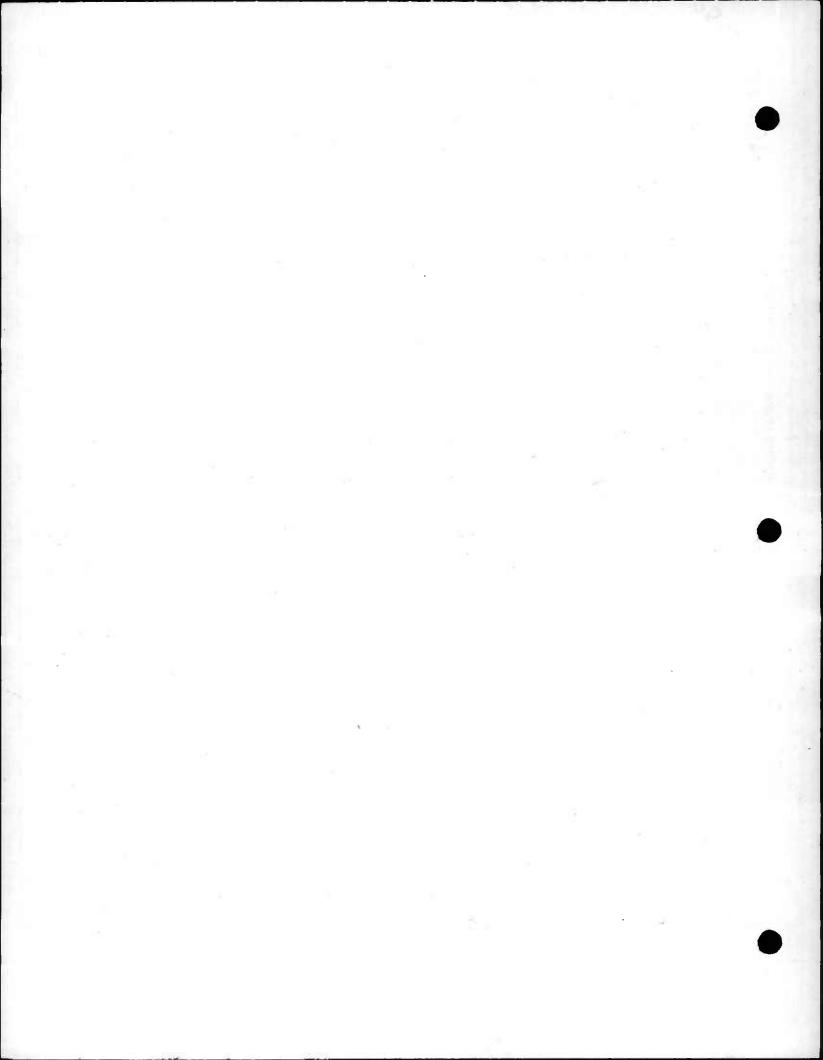
DHMH-16 Rev 1/89

BOX 68760	
P.O.	
RECORDS,	
OF VITAL	
DIVISION	

		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPA	RTMENT OF I	HEALTH AND I	MENTAL	HYGIENE REG. NO.				
140		1. DECEDENT'S NAME (First, Middle, Last) BERNICE	BROWN				2. DATE O MONTH MAY			3. TIME OF DEAT		
2		4. SOCIAL SECURITY NUMBER 217-34-4308	1 M 2 🔀 F	fin yrs. lest birthde;	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE O		8, 6	BIRTHPLACE (State or Fo		
2, 3 should	стоя	9a. FACILITY NAME (If not institution, give st  THE JOHNS HOPKINS RESIDENCE OF DECEDENT			1000	ORE CITY	ATH		9c. COUNTY			
ft. Pages 1,	DIREC	100. STATE 10b. COUNTY MARYLAND	N/A	10c. C	BALTO.					10d. INSIDE CITY LIMITS?		
n. ansit permit.	FUNERAL	3004 OAKLEY A	VE.		10	21215			-	OF WHAT COUNTRY? ED STATE		
5-0020 nding physician. ss the bunal-transit	TO BE COMPLETED BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 M Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR DO	2X NO	If yes, sp	CENDENT OF HISPAN secify Cuban, Maxica 2 X NO Specify	(Specify Yea or can, etc.)	y Yea or No— 14. RACE — Amer Black, White, I Specify: BLAC		iri,		
pital or atte		15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) 12TH		(Give kind o life. Do NOT	S USUAL OCCUPATION of work done during mouse retired.)	ON ost of working	166. KIND OF BUSINESS/INOUSTRY RESTAURANT			RY		
3 B B B		17. FATHER'S NAME (First, Middle, Last) PHILLIP HUTTO			JOOK	18. MOTHER'S NAI	mame)					
ay be retained lay be retained lay be be notified		196. INFORMANT'S NAME (Type/Print)  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  MARGARET GASKINS  3004 OAKLEY AVE. BALTO, MD. 2121										
nector.	23	20e. METHOD OF DISPOSITION X Burlal 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	val from Stata	PLACE AND DAT	EOF DISPOSITION (No. other place).	M 5-9-				or Town, Stata ARYLAND		
4 % Z X		21. SIGNATURE OF FUNERAL SERVICE LICE	Acrugio	a, fr	CALV	IN B. S E. PRE	CRUG	ST.	BAT.TO	L HOME	213	
hours after titled in by mation, or remode it, the medical		23. PART I. Enter the disesses, or content fellure. I immediate Cause (Finel disesse or condition resulting in death)	Interpolation of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of	ach line.	not enter the mo	de of dying, such	n se cerdia	c or reapira	tory arreat,	Approxime Interval Be Onaet and	ete etween I Death	
th certificate be execute ending physician and cult hygiene prior to buria or other traumattic	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury  L. Chronic Ofstrictive Pulmonary disease  To bacco USE  C. To bacco USE										
v requires that the been signed by the t. of Health and M. shows any Injury	ME.	PART II. Other significent conditions Covoursy of Myocardial DID TOBACCO USE CONTR	viery dis	ease	in the underlying	g ceuse given in i	1	48. WAS AN AU PERFORME YES 2	ED?	24b. WERE AUTOPSY FIN AVAILABLE PRIOR TI COMPLETION OF CO OF DEATH? 1 YES 2 N	TO AUSE	
The la	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DE	ATH (Check only one) OTHER:	e 5 🗆 Rasidenca		Specify)				
Te sis E	ву рну	27. MANNER OF DEATH  1 Netural 5 Pending 2 Accident Investigation	28a. OATE OF INJURY (Month, Day, Year)		ME OF 28e, INJ	URY AT PRK? YES 2 NO		RIBE HOW INJU	URY OCCURE	D	-	
OR ATTENDING DIRECTOR: After hours after death item 28 is ma	ETED	3 Suicide 8 Could not be determined	28a. PLACE OF INJURY building, etc. (Spec	ify)			City or	Town, State)		ural Route Number,		
世 32年	COMPL	(Check only 1 SCENTIFYING PHYSIC One) 2 MEDICAL EXAMINER	IAN: To the best of my knowl : On the basis of examination							use(a) and menner as st	eted,	
TO THE HOSPI TO THE FUNEF be filed within	TO BE	295. SIGNAFURE AND STILE OF CERTIFIER  3E. HAME AND ADDRESS OF RIPISON WHO	COMPLETED CAUSE OF DE		O Chilata	29c. LICENSE NUM	BER	2	9d. DATE SIO	NED (Month, Day, Year)		
4	Í	- 000 - 1				Hespital	2 , 6	Sa Ofm	Lane . I	MD 21283	2	



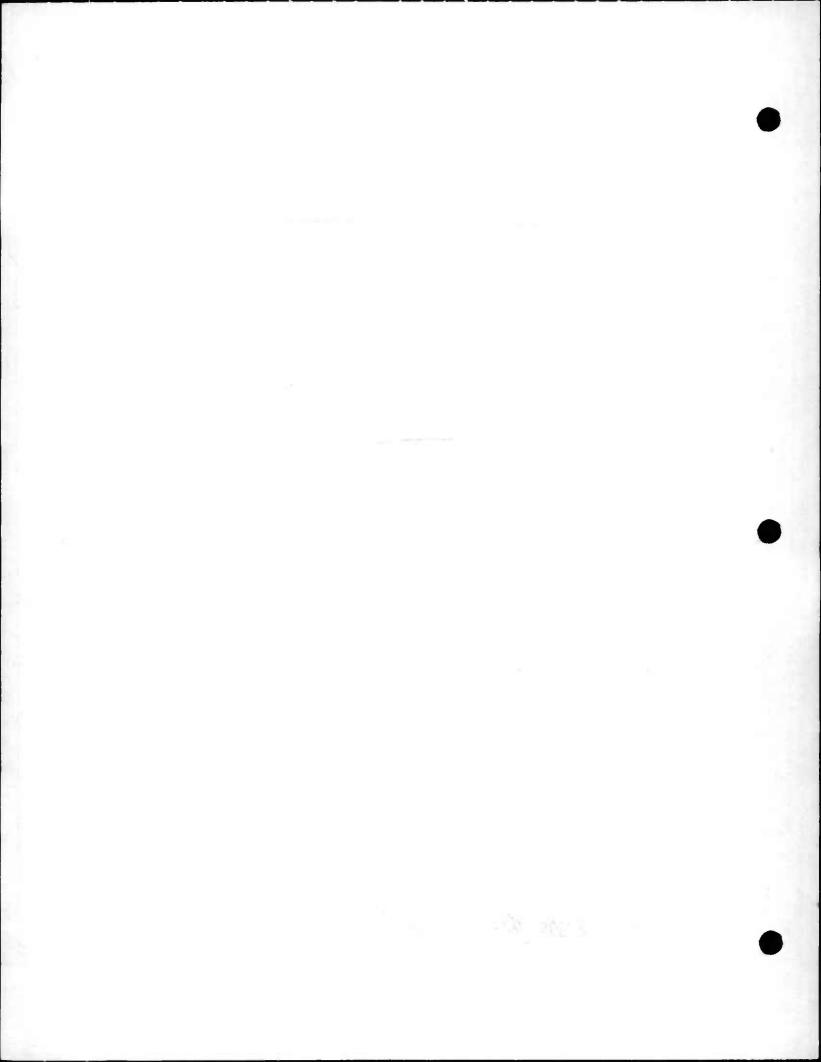
											9	5	13406	
	1 - FOR STATE REGISTRAR	STATE OF MA		) / DEPAR						YGIENE	E			
	1. DECEDENT'S NAME (First, Middle, Last)  Maurice Stel	wart Cam	eron						2. DATE OF MONTH	DEATH DAY	199	5 YEAR	3. TIME OF DEATH 8:30 A. M	
	212-09-4907	1 💢 M 2 🗆 F	8. AGE (In yrs. 86	last birthday) YRS.	IF UNDER	1 YEAR DAYB	IF UNDER	24 HRS.	7. DATE OF E (Month, Da JULY	DARWINA A		8. BIRTHI Country	PLACE (State or Foreign	
OR	80. FACILITY NAME (If not institution, give street 2511 Mountain R			96. CITY, TOWN OR LOCATION OF DEATH  Joppa							BC. COUNTY OF DEATH HARford			
ECT	RESIDENCE OF DECEDENT  10e. STATE  10b. COUNTY			10c. CITY, TOWN OR LOCATION										
PIG .		arford				Jopp	_						10d. INSIDE CITY LIMITS? 1 YES 2 NO	
FUNERAL DIRECTOR	100. STREET AND NUMBER 2511 Mountain Ro	ad			101.	210				10g. CIT		HAT COUNTRY?		
FUNE	11. MARITAL STATUS	2. WAS DECEDENT FORCES? 1	EVER IN U.S.	ARMED	13. V	WAS DECI	ENDENT O	F HISPAN	IC ORIGIN? (S	pecify Yes	or No-		- American Indian, White, etc.	
ВҰ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WA		<u></u>	_   "	YES	2 NO	Specify	n, Puerto Ricer	i, etc.)			white	
ETEC	15. DECEDENT'S EDUCAT (Specify only highest grade co Elementary/Secondary (0-12)	mpleted)	18e.	OECEDENT'S (Give kind of life. Do NOT us	USUAL OC work done d se retired.)	CUPATID	N at of workin	g	16b. KIN	D OF BUSI	NESS/IN	DUSTRY		
COMPLETED	11th grade	College (1-4 or 5+)		Shippi	ng Fo	rem	an		S	hipp	ing	Compo	iny	
BE CO	17. FATHER'S NAME (First, MIOOR, Last)  Daniel Cameron								ROUS		iumeme)			
TO B	190. INFORMANT'S NAME (Type/Print) Rose S. Cameron	Joppa,	MD	State, Zip										
	204, METHOD OF DISPOSITION  1  Buriel 2  Cremetton 3 Remove  4  Donation 5 Other (Specify)	CEANDDATE	OF DISPOSI	TION (Ner	me of		DATE	20c. LOC		City or Tow	rn, State Vryland			
	21. SIGNATURE OF FUNERAL SERVICE LICEN	Tring		22. N SC	him	D ADDRES	Fun	eral H	omes.	. In	c.			
	23. PART I. Enter the dispases, or complications the caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, interval Between													
	IMMEDIATE CAUSE (Final disease or condition	0		12) [114.									Interval Between Onget and Death	
	resulting in death)												4 mo	
NO	Sequentially list conditions,  DUE TO (DP) AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):												4 mo	
CATI	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	502 10 (0	A A CON	SEDUENCE OF	1.	1/	4	m	9					
ERTIFICATION	that initiated events reaulting in death) LAST	DUE TO (O	R AS A CONS	BEDUENCE OF	F):	U			0					
O	PART II. Other aignificant conditions of	contributing to de	eath but no	t resulting	In the unc	terlying	cause g	Iven in i	Part I. 24a	. WAS AN A			WERE AUTOPSY FINDINGS	
PHYSICIAN: MEDICAL									10	PERFORM			AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
Z: M	DID TOBACCO USE CONTRIE	BUTE TO CAU	SE OF DE	ATH YE	s Ex	ю П	UNC	ERTAIN		_/	,		1 - YES 2 - NO	
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:	26. PL	ACE OF DEAT		nly one)								
HYS	1 YES 2 DIO 1	20e. DATE OF IN	JURY	28b. TIM	4 🗆 Nural	ng Home 28c. INJU	JRY AT	sidence (	28d. DESCRIE		JURY OC	CURED		
ВУ Р	1 Accident   Fending Investigation	(Month, Day,		INJURY WORK?  M 1 YES 2 NO										
TED	3 Suitcide 6 Could not be 4 Homicide determined	28e. PLACE DF I building, ato	c. (Specify)	home, ferm, a	itreat, fecto	ry, office			28f. LOCATIDE	N (Street an wn, State)	nd Number	or Rural Ro	oute Number,	
COMPLET	29s. CERTIFIER (Check only one)  ANSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated.  ADDICAL DIAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner es stated.													
BE CO	29b. SIGNATURE AND TITLE	/			., , ,	1	29c. LICE				29d. DAT		Month, Day, Year)	
_		111		_		- 1	1) 7	つる(	19	- 1		MIN	TILE ICGO	



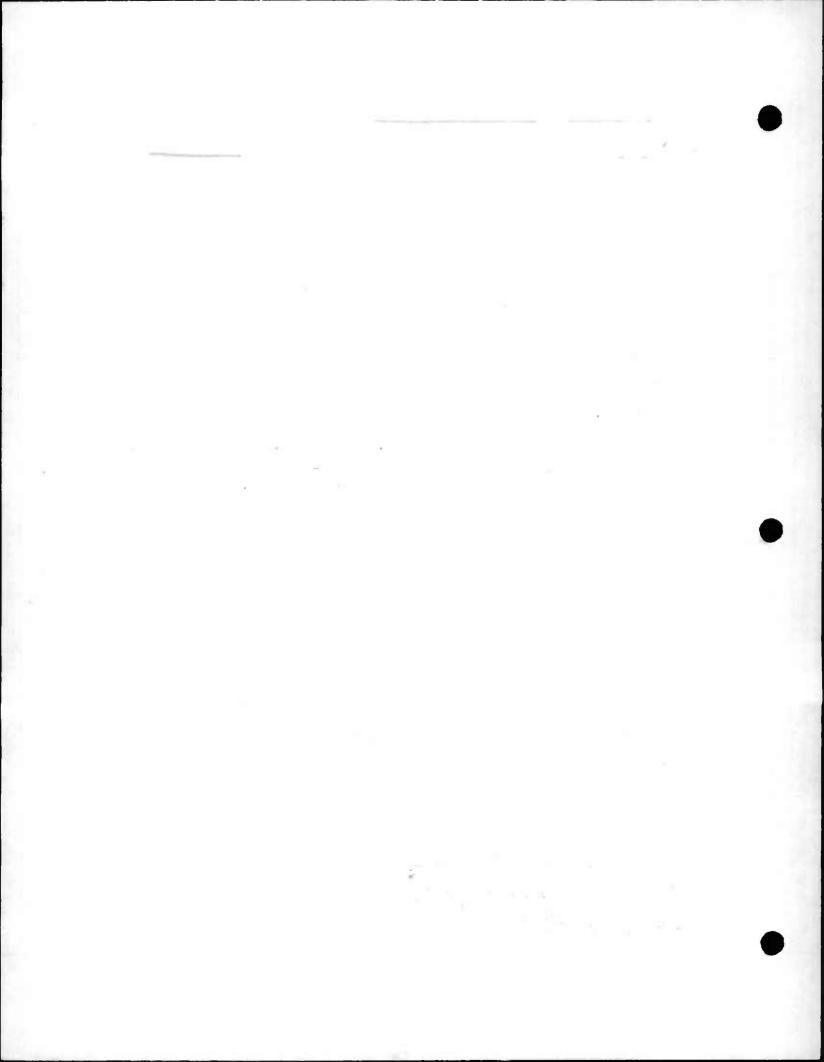
DIVISION OF VITAL RECORDS, P.O. BOX 68760

AME (First, Middle, I	Lest)					2 DATE OF DE	ATAI				_
1		C	ERTIFICA	TE OF	DEATH	REC	3. NO.				
	STATE OF	MARYLAND .	/ DEPARTME	NT OF H	EALTH AND	MENTAL HY	GIENE	L . [] .			
FilmG.	723, it	em #10b	100	20h	5/5/91	a cuu	ner	95	13	40	1

	1. DECEDENT'S NAME (First, Middle, Li	est)		CATE OF		REG. N 2. DATE OF DEATH MONTH		3. TIME OF OEATN									
	Shirley 4. SOCIAL SECURITY NUMBER	Ann	Chase			May 1,	1995	12:32									
	219-36-8160	1 M 2 💢 F	54 yrs.	F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	AUG". 11;	1940	BIRTHPLACE (State or Foreig DSBY, MARYLAI									
TOR.	BAYVIEW HOSPI	TAL			TIMORE	CITY	9c. COUNT	n/a									
DIRECTOR	MARYLAND 106. COL	n/a HARFOI		TOWN OR LOCAT	IMORE	10d. INSIDE CITY  VALIMITS?  1 TYES 2 NO											
FUNERAL	2022 HANSON	ROAD		101	ZIP CODE 2104	0		TED STATES									
BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 _ YES IF YES, GIVE WAR OR D	2 NO	If yes, sp	3. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify, Cuben, Maxican, Puarto Rican, atc.)  1 YES 2 NO Specify:  Specify:  BL												
ETED	15. DECEDENT'S I (Specify only highest gi	EDUCATION mide completed)	16a. DECEDENT'S U (Give kind of wo life. Do NOT use	rk done durina mo	ON at of working	USINESS/INOUS	STRY										
PE	Elementary/Secondary (0-12)	College (1-4 or 5 +)	FOSTE		NT	in ow	in own home										
TO BE COMPL	17. FATHER'S NAME (First, Middle, Last) THOMAS	GOUGH				MOTHER'S NAME (First, Middle, Meiden Sumame) PAULINE COATES											
		HASE	2022	HANS	ON ROAD	Route Number, City or T	D, MAR	YLAND 2104									
	28a, METNOD OF DISPOSITION  1X XBurlal 2	lemoval from Stata 201	DK DEKE	DISPOSITION (Na	CEM.			y or Town, Sleta MARYLAND									
	21. SIGNATURE OF FUNERAL SERVICE		DIV. DEIXE		ID AOORESS OF FA		CLAIN,	MARTEAND									
	1 tonac	D/1	The same	WM. C	. MARCH	FH1101	E . NO	ORTH AVE.									
CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart feliure. List only one cause on each line.  IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Metabolic Acidosis  OUE TO (OR AS A CONSEQUENCE OF):  Acute Renal Failure  DUE TO (OR AS A CONSEQUENCE OF):  CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or Injury CAUSE (Disease or I																
	that initiated events resulting in desth) LAST  DUE TO (OR AS A CONSEQUENCE OF):  d.  PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY PINDIN																
MEDICAL	Pnuemonia, DM		the underlying	j cause given in	PERFORMEO?  1 Yes 2 NO OF DE												
ä	DID TOBACCO USE CON				UNCERTAIN	N 🖾		1 TES 2 X NO									
0	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 X NO	HOSPITAL:		THER:													
SICIA		28a. DATE OF INJURY	28b. TIME	OF 28c. INJU		8 U Other (Specify) 28d. DE\$CRIBE HOW	INJURY OCCUP	REO									
Y PHYSICIAN:	27. MANNER OF DEATN  1 X Natural 5 Pending	(Month, Day, Year)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
ED BY P	1 Natural 5 Pending 2 Accident Investigate 3 Suicide a Could not	28e. PLACE OF INJURY building, atc. (Spe	f — At home, farm, atri	eet, fectory, affice		City or Town, Stat	4 Hemicide detarmined building, stc. (Specify)  City or Yown, State)										
ETED BY P	1 X Netural 2 Accident 3 Suicide 4 Homicide  29e. CERTIFIER (Check only)  1 X CERTIFYING PM	28e. PLACE OF INJURY building, stc. (Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special Special S	rledge, death occurred	at the lime, data	and place, and due	City or Town, Stat	anner ee stated.										
BE COMPLETED BY P	1 X Natural 2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only one) 2 MEDICAL EXAM 29b. SIGNATURE AND TITLE OF CERTIF	28e. PLACE OF INJURY building, etc. (Special Property of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of examination of the basis of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examinati	riedge, death occurred in and/or investigation,	at the time, data in my opinion, de	and place, and due seth occured at the 29c. LICENSE NUM	City or Yown, State to the cause(e) end m time, data and place, or	enner ee steted. and due to the c	HIGNEO (Month, Day, Year)									
COMPLETED BY P	1 X Natural 2 Accident 3 Suicide 4 Homicide  290. CERTIFIER (Check only one) 2 MEDICAL EXAM  29b. SIGNATURE AND TITLE OF CERTI	28e. PLACE OF INJURY building, etc. (Special Property of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of examination of the basis of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examination of examinati	riedge, death occurred in and/or investigation,	et the time, deta In my opinion, de	and place, and due eath occured at the 29c. LICENSE NUN 9366	City or Yown, State to the cause(e) end m time, data and place, or	enner ee steted. and due to the c  29d. DATE S  May  Cal Cen	HONEO (Month, Day, Year)  1,1995									



		1 - STATE REGISTRAR	SIAIE UF MAN				F DEATH	D MENT	AL HYGIE! REG. NO				
		1. DECEDENT'S NAME (First, Middle, Leet)	James E	_		Cig		2. DAT	E OF OEATH		(EAR 3. TIME OF DEATH		
		4. SOCIAL SECURITY NUMBER	5. SEX 8. A	GE (In yrs. les	it birthday)	IF UNDER 1 YEA	R IF UNDER 24 HR	8. 7. DAT	E OF BIRTH	019	BIRTHPLACE (State or Foreign		
-	-	219-18-3138	1 2 M 2 🗆 F	69	YRS.	MONTHS DAY		N. (Moi	100/16	25/25	Country)		
3 should		9e. FACILITY NAME (If not institution, give s	treet end number)		-	9b. CITY, TOW	N OR LOCATION O	F DEATH	3/11/	9c. COUNT	Maryland Y OF DEATH		
2,	DIRECTOR	JOHNS HOKEN	S GERIA	TRIC	sce	ut.	BALTI	Mor	3F	N	/A		
Pages 1	3	10e. STATE 10b. COUNT	2 2		10c. CIT	Y, TOWN OR LO					10d. INSIDE CITY LIMITS?		
	1	Maryland	Baltimor	e		Dundalk							
permit.	FUNERAL	10g. STREET AND NUMBER					101. ZIP CODE	1000		10g. CITIZE	N OF WHAT COUNTRY?		
020 physician. burial-transit	ÿ	6819 Roberts Ave						1222	United States				
020 physician burial-tra		11. MARITAL STATUS  1 Never Married 2 Merried	12. WAS DECEDENT EVE FORCES? 1 7 Y IF YES, GIVE WAR O	ER IN U.S. AR	MED	If yes,	DECENDENT OF HIS specify Cuban, Me	xican, Puerto	IN? (Specify Ye Rican, atc.)	a or No— 14	i. RACE — American Indian, Black, White, etc.		
	B	3 Widowed 4 Divorced	Kanaan	R DATES	vw II	10'	res XIX NO so	pecify:			Specify: White		
1215-0 r attending use as the	COMPLETED	15. DECEDENT'S EOU (Specify only highest grade	CATION	16a. DE	6a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working				ib. KIND OF BU	ISINESS/INDUS	STRY		
10 a v		Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT us	se retired.)	most or working						
AND in the hospital detached for once.		11 Years		<i>k</i>	Brake	man				Road			
YLA by the be det		17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NAME (First, Middle, Melden Surneme)  Agnes Catherine							
	8	NOT KNOWN  190. INFORMANT'S NAME (Type/Print)		191									
5 5 5	2	Lucille M. Cigar	ok	ek 6819 Roberts Avenue Baltimore, MD									
ORE, 6 may be ctor, page		20e. METHOD OF DISPOSITION			21222 y or Town, State								
2 9 9 -		1 X Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 8 ☐ Other (Specify)	ovel from State	Sacre	a Hit	her place	ary Cem.	5/5/	95 D	undalk	. Maryland		
ALTIM death, Page funeral dire		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			22. NAME	AND ADDRESS OF	F FACILITY	al Ham	0 0/ 1	undalk, Inc.		
BALT ter death, the funera wal.		> Scorl 7	Jano-			79	22 Wise	Avo.	Dunda	lb Ma	ryland 21222		
hours after hours after or removal medical		23. PART I. Enter the diseases, or o	complications that cau	sed tha de	ath. Do n								
hour filed in n, or		shock, or heart failure. iMMEDIATE CAUSE (Finel	List only one cause o	n each line							Interval Between Onset and Death		
thun Z etely fi matio		disease or condition											
ded within complete al, cremis event,			DUE TO (OR A	AS A CONSEC	S A CONSEQUENCE OF):								
and control burit	NO N	Sequentially list conditions, If any, leading to immediate											
Sician orior to	Ä	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury c											
Tificat d phy iene p	Ĕ	CAUSE (Disease or injury thet initiated events	DUE TO (OR A	S A CONSEC	UENCE OF	7:	014000		evei	u	MORINES		
th cer tendin	ERTIFICATION	resulting in death) LAST	d										
the dea y the att nd Menta	O	PART II. Other aignificent condition	a contributing to deat	h but not n	esulting i	n the underly	ing cause given	in Part i	24a, WAS AN	ALITOREY	Ash With Allenday Francisco		
₹ g g g >	CAL		ilupe,					al Part I.	PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE		
Sign Realt	MED	Cholecustitis		CI	4	Joen	~/		1 TYES	NO	OF DEATH?		
_ ~ ~	2	DID TOBACCO USE CONTI	7	OF DEA	TH YE	S 🗆 NO	UNCERT	AIN D			1 PES 2 NO		
: The law cate has be state Dept.	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				'H (Check only o			1				
SICIAN: The certificate the State , or Item	VSIC	1 YES 2 NO	HOSPITAL: 1 ☐ Inpetient 2 ☐ ER/C	Outpatient 3	□ DOA	4 Williams H	ome 5 🗌 Residen	ce 8 🗆 Oth	er (Specify)				
PHYSIC this cer with th	PH	27. MANNER OF DEATH  1 Natural 5 Pending	28e. DATE OF INJUI (Month, Day, Yes		26b. TIMI		INJURY AT WORK?	28d, DE	SCRIBE HOW	NJURY OCCUP	RED		
DING PHYS After this death with	B	1 Natural 5 Pending 2 Accident Investigation					YES 2 NO						
28 I after	9	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJU building, etc. (5	URY — At her Specify)	ne, farm, s	treet, fectory, o	fice		CATION (Street or Town, Stete)		Rurel Route Number,		
OR A DIRECT HOURS	ET	290. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of my kr	nomindos dos	dh assum	d at the store of							
로 로 전 ==	COMPL										euse(e) end manner as stated.		
THE HOSPI THE FUNER filled within		29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (M.											
日 6 8 8 M M M M M M M M M M M M M M M M M	TO BE	/www	-		D41955 > 5-1-95								
		30. NAME AND ADDRESS OF PERSON WH	COMPLETED CAUSE OF	-	127) (Type,	Hopkin	ns Gevi	atri	cs Con	Her	Bultimore		
		MAY 0 5 1995	R REGISTRANCE	IGNATURE Mall	-			,					



DIVISION OF VITAL RECORDS, T.O. BOX 13149, BALLIMORE, MARTLAND 21203-3146
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing. Four after death, Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF I		/ DEPAF					MEN	TAL HYGIEN REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last) Bertha			Coom					2. D/	ATE OF DEATH	10	3.	TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER	5 SEX 6 AGE (In vir. last hirthday) IF IMPER 1 YEAR IF IMPER 24 MIS 7 DATE OF BIRTH										ACE (State or Foreign		
	212-26-4412	1 🗆 M 2 🔀 F	89	YRS.	MONTHS	DAYS	HOURS	MIN.	2	28 19	06	Country)	TOE (create or ) or organ	
	9a. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY, TOWN OR LOCATION OF DEATH						9c. COUN	TY OF DEAT	ЛН	
HOT.	Pleasant Manor	Nursi	ng Cen	ter	Ba	1ti	mor	е			N/A			
DIRECTOR	MD 10a. STATE 10b. COUNTY	LIA		10c. CIT	гу, тоwn о Ва		mor	e				Od. INSIDE CITY LIMITS? YES 2 NO		
RAL	10e. STREET AND NUMBER	ro Boad			10f. ZIP CODE 21212						10g. CITIZ	U S	AT COUNTRY?	
FUNER	529 Tunbride		IT EVER IN U.S. A	RMED	13 V	MAS DEC			HC OB	IGIN? (Specify Ver	or No		- American Indian,	
B	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 X NO Specify:											Black, W	Vhite, etc.	
밀	15. DECEDENT'S EDUCATION  16e. DECEDENT'S USUAL OCCUPATION  16b. KIND OF BUSINESS/INDUSTRY													
IPLE	Elementary/Secondary (0-12) College (1-4 or 5 +) life. Do NOT use retired.)													
	17. FATHER'S NAME (First, Middle, Last)  M. DEED  18. MOTHER'S NAME (First, Middle, Melden Surname)  LInknown													
8	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	3 ADDRESS	(Street a	nd Numbe	r or Rural I	Route A	Number, City or Tow	n, State, Zip	Code)		
유	kennth Younge	r		231	8 ED	MON	DSO	N AV	E	BALTO,	MD	2122	.3	
	20a. METHOD OF DISPOSITION  1 X Burlal 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	20b. PLAC other MT	e of dispo	SITION (Na/ BURN	ne of cen CE	MET	matory or ERY	5/	/ /	LTO,	MD	, Stata	
	21. SIGNATURE OF FUNERAL SERVICE LIN	A. D	homp	sm I	-			ESS OF FA		ST 430	O WA	BASH	AVE	
	23. PART I. Inter the diseases, or a shock, or heert failure.				not enter	the mo	de of dy	ring, suc	h as c	cerdiac or respi	ratory arr	est,	Approximate interval Between	
	IMMEDIATELCAUSE (Final disease or condition					/	100	hu	7	-la m			Onset end Death	
	resulting in death)	e. DUE TO	O (OR AS A CONS	EOUENCE O	OF):			4001	-1	m.m. Dise	0.50		YEARS	
NO.	Sequentielly liet conditions, if any, leading to immediate	b. DUE TO	O (OR AS A CONS	EQUENCE O	) 100 / 1 0F):	07/0	/	1201		0134	-u • C		TOMES	
-ICA	ceuse. Enter UNDERLYING CAUSE (Diseese or injury	c	OR AS A CONS	FOUFNCE (	nen:									
CERTIFICATION	that initiated events resulting in death) LAST	d												
2	PART II. Other eignificant condition	s contributing to	death but not	t resulting	in the un	derlying	g ceuse	given in	Part I	i. 24a. WAS AN	AUTOPSY	24b. W	ZERE AUTOPSY FINDINGS	
2	14	MPER	TENSI	ON				1.		1 TYES 2	-	0	MAILABLE PRIOR TO OMPLETION OF CAUSE OF DEATH?	
MEDIC													YES 2 NO	
													Y	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1  YES 2 A	HOSPITAL:		• 🗆 = • •	OTHER	3:		DEATH (Ch						
HAS	27. MANNER OF DEATH	1 Inpatient 2 28a. DATE O	F INJURY	28b. TII	ME OF	28c. INJ	URY AT	lesidence	_	Other (Specify) DESCRIBE HOW I	NJURY OCC	CURED		
ВУ Р	1 A flatural 5 Pending 2 Accident Investigation	(Month,	Day, Year)	AI II	JURY M		YES 2	□ NO						
8	3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE building	OF INJURY — At i, atc. (Specify)	home, farm,	street, fact	ory, offic	:0		261.	LOCATION (Street City or Town, State)	and Number	or Rural Rou	te Number,	
COMPLET	29s. CERTIFIER (Check only)  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  Check only  C													
NO.	one) 2 MEDICAL EXAMINI	ER: On the besia of	examination and/o	or investigat	ion, in my o	plnion, d	leath occu	ured at the	time,	date and place, ar	nd due to th	e cause(a) a	nd manner as stated.	
BEC	296. SIGNATURE AND TITLE OF CERTIFIE	R O	MA	01	1		29c. LIC	ENSE NU	MBER			E SIGNEO (A	Aonth, Day, Year)	
2	30, NAME AND ADDRESS OF PERSON W	O COMPLETED CA	ISE OF DEATH (I)	TEM 27) (%n)	na Print)			13	66	4	1	nay	- 1, 1773	

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M.D.

HUSELEVE CHOOLING

Veneracion,

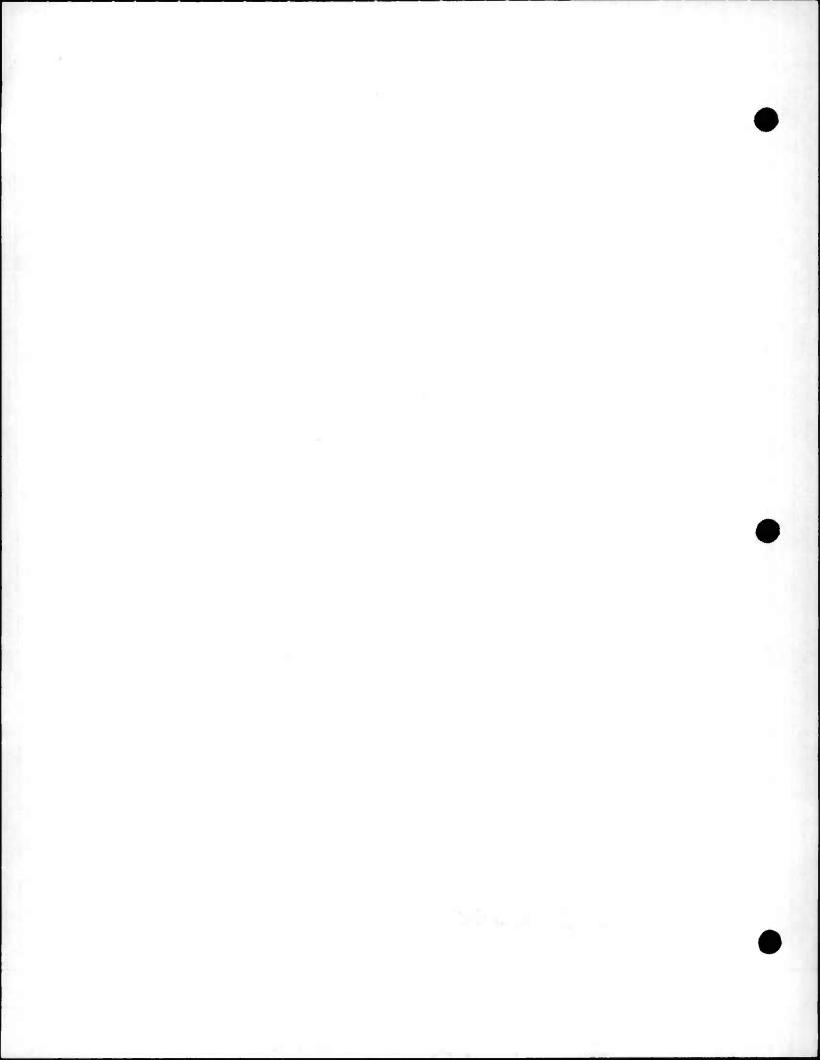
B.C.

MAY 0 5 1995

1576 Merritt Blvd., Baltimore,

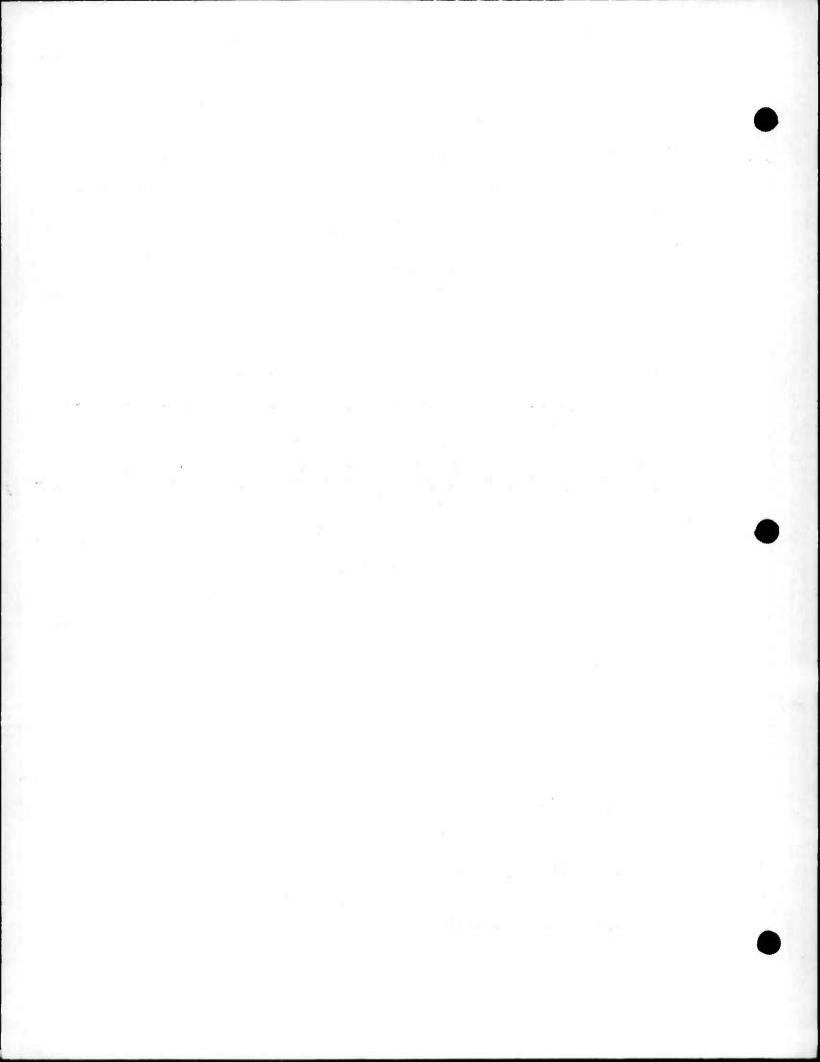
- a man with the second

		FOR STATE REGISTRAR	STATE OF MARYLAND	) / DEPARTMEN CERTIFICAT			MENTA	AL HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Lest)  HENRY	COLEMAN				2. DATI MON	E OF DEATH	AY	YEAR 3	TIME OF DEATH
Pin		4. SOCIAL SECURITY NUMBER 213-07-9725		6 YRS. MONTHS	-	IF UNDER 24 HRS. HOURS MIN.	AUG	of BIRTH th, Day, Year)			ACE (State or Foreign H CAROLI
, 2, 3 should	ECTOR	sa. FACILITY NAME (If not institution, give stated of the state of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the stated of the s		9b. CIT		LTO. C.	EATN	Y .	9c. COUNT	9c. COUNTY OF DEATH  N/A	
permit. Pages 1,	DIREC	10a. STATE 10b. COUNTY	N/A	10c. CITY, TOWN		LTO. C	 [TY			Dd. INSIDE CITY LIMITS?  X YES 2 \( \text{NO} \)	
n. ansit perm	IERAL	100. STREET AND NUMBER 816 BROOKSLANE			101	ZIP CODE 21217	10g. CITIZEN C				
215-0020 attending physician. ise as the burial-transit	BY FUNI	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 N Divorced	12. WAS DECEDENT EVER IN U.S. FORCES? 1 XYES 2 I IF YES, GIVE WAR OR DATES WWIII		If yea, spi	ENDENT OF HISPA ecity Cuban, Maxic 2 NO Speci	ANIC ORIGIN? (Specify Yes or No— 14. R cen, Puerto Ricen, etc.)				American Indien, White, etc.
D 21 spital or led for u	E COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION 16a	ON st of working	16b. KIND OF BUSINESS/INDUSTRY  TOWSON STATE L						
# 88 X		17. FATNER'S NAME (First, Middle, Lest)  MILES COLEMAN		LIBRAF		18. MOTHER'S NA			,		
be retained by ge 5 should be notified at	TO B	19a. INFORMANT'S NAME (Type/Print)  ESTELLE CHRIST	мдс		RESS (Street and Number or Rural Route Number, City or Town, State, Zi  BROADWAY BALTO, MD						2
FORE of may rector, pa		20s. METHOD OF DISPOSITION 1 M Burlel 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	val from State 20b. PLAC cometent GAR	CE AND DATE OF DISPO Crematory or other place RISON FO	RES'	""5-10-9 T VET.	5 DAY	TO M  TE 20c. LOC  OWI	CATION — CIT		
W - 8 H 8		alven B,	Sugar,	Ac. 2	CALV	IN B. S	CRU	GGS FI	UNERA	L H	
760 BA  Moduling 24 hours after of purpletely filled in by the littermation, or removal.		IMMEDIATE CAUSE (Final	omplications that caused that list only one cause on each if	death. Do not antaina.	r tha mod	de of dying, suc	ch aa car	diec or reepl	ratory erres	t,	Approximate Interval Between Onset and Death
68 xecute and c buria	NOI	Sequentially list conditions, if any, leading to immediate	HYPERISA  DUE TO (OR AS A CONS	LEMIA							10 Hours
certifical nding phy Hygiene p	RTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):								20 YEARS
RDS, lat the deal by the att and Menta y Injury,	ICAL CE	PART II. Other significant conditions	contributing to death but no	cause given in	Part 1.	24a. WAS AN A	MED?	AV.	ERE AUTOPSY FINDINGS AILABLE PRIOR TO OMPLETION OF CAUSE		
REC w requires been sign xt. of Heal	N: MEDI	DID TOBACCO USE CONTR	IBUTE TO CAUSE OF DE	ATH YES	NO 🛭	UNCERTAI	— N П	1 🗀 YES 2	NO NO	OF	DEATH?
/ITAL F N: The law ficate has be State Dept.	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		ACE OF DEATN (Check	only one)						
		27. MANNER OF DEATH 1 ☑ Netural 5 ☐ Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJU	RK?		SCRIBE NOW IN	JURY OCCUP	RED	
ISIC TTENDI TTENDI TTOR: A after de	TED BY	2 Accident Investigation 3 Suicide S Could not be datermined	26a. PLACE OF INJURY — At building, atc. (Specify)	home, farm, street, fac	M 1 YES 2 NO  street, factory, office  281. LOCATION City or You				I (Street and Number or Rural Route Number, rn, State)		
DIS OUT THE	COMPLETE		IAN: To the beat of my knowledge, : On the basis of examination and/s							ause(a) ar	id manner as stated.
TO THE HOSPITAL TO THE FUNERAL TO THE FUNERAL TO be filed within 72 h	BE	29b. SIGNATURE AND TITLE OF CERTIFIER  MCQTTUC 1		*		29c. LICENSE NUI				IGNED (M	onth, Day, Year)
5	0	30, NAME AND ADDRESS OF PERSON WHO DR. ROWENA CAS TREA	CT GOOD SAMAI	RITAN HOSI	PITAL						
		MAY 105 1995 " Julia	137 FERENCE OF TURE								



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HOSPITAL ON ALLENDING PHISICIAN: THE ISW REQUIRES THAT THE GREAT CEPTIFICATE BE EXECUTED WITH THE TROUB ATTEL TOOK THE TRUE TO THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE THE TRUE TH	E FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detact	
te	the state	200
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MILITER	pletely	within 79 hours after death with the Crote Dane of Martin Maries Livings orige to burief gramming or same
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		FOR 1 - STATE		STATE OF	MARYL						MENT		E .	0 10411		
		REGISTRAR  1. DECEDENT'S NAME (First, Mic	rirlia ( aat)			CE	KIIFI	CATE O	P D	EATH	T	REG. NO		-		
		Helen M.	Fit:								Mon 5		<u> </u>	3. TIME OF DEATH 95 1/20 A		
-		082-22-6653	1	5. SEX	6. AGE	(In yrs. last b		MONTHS DAY		OURS MIN.	7. DAT	e of BIRTN oth, Day, Year) 27,1		B. BIRTHPLACE (State or Foreign Country) NEW YORK		
3 should		90. FACILITY NAME (If not institu	rtion, give str	eet end number)				9b. CITY, TOW	N OR I	LOCATION OF D				Y OF DEATH		
~	TOR	Calvert Men	noria	al Hosp	ita	1		Princ	e l	Frede	rick		Ca	lvert		
physician. burial-transit permit. Pages 1,	DIRECTOR	MD A	Anne	Arunde	1			urchton						10d. INSIDE CITY LIMITS? 1 1 YES 2 NO		
in. ransit pen	FUNERAL	5558 Frankl	lin F	Blvd.			10f. ZIP CODE 20733						EN OF WHAT COUNTRY?			
attending physician. se as the burial-tran	ED BY FU	11. MARITAL STATUS 1 Never Married 2 Mar 3 X Widowed 4 Divorced	rried d	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES	2 VNO	0	If yes,	specificES 2	y Cuben, Mexic	an, Puerto Rican, atc.)			4. RACE — American Indian, Black, White, atc. Specify: White		
_ 3		(Specify only hig		ATION completed)		18e. DECE (Give	DENT'S U	ISUAL OCCUPA ork done during retired.)	MOSt o	f working	16	b. KIND OF BUS	INESS/INDU	STRY		
spital ed fo	COMPLET	Elementary/Secondary (0-12)		College (1-4 or 5	+)	100		raphe				US Go	vernn	nent		
be der	BE CO	17. FATHER'S NAME (First, Middle John	Cr				18. MOTNER'S NAME (First, Middle, Melden Surneme) Helen Walsh									
be retained to ge 5 should e notified	10	190. INFORMANT'S NAME (Type) Leo J. Fitz		ald Jr.		196. A	58 ]	rakl	et end i	Number or Rural	Route Nur Ch	urcht	on, State, Zip C	AD 20733		
6 may ctor, pa		20e. METHOD OF DISPOSITION 1		val from State	20b	PLACE AND	DATEO	er place) Cel	(Name	me of QATE 20c. LOCATION — City or Town, State						
Page al dire		21. SIGNATURE OF FUNERAL SE		HSE		<b>c.</b> 0	1100	22. NAME	AND A	ADDRESS OF F	CILITY					
9 7 6		Thomas	41	fandl	esty	76		12	Ric	dgely	Ave	al Ho	apoli	is, MD 21401		
ted with the hours after completely filled in by the ial, cremation, or remove event, the medical														at, Approximata Interval Between Onset end Death 2 Lagy		
ertificate be execuing physician and rgiene prior to bur other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  JUANA  J														
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law requast been bept. of 23 sho		DID TOBACCO USE		IBUTE TO CA	USE O	F DEATH	YES	□ NO	0	UNCERTAI	N 🗆					
The ste th	PHYSICIAN:	25. WAS CASE REFERRED TO ME EXAMINER?		HOSPITAL:				(Check only or	ne)							
icial pertif	14S	1 TYES 2 NO		1 Inpatient 2 28e. DATE OF		-	Bb. TIME			Residence				-		
PHY this with	BY PI	1 Natural 5 Pend	ding stigation	(Month, D	ay, Year)		INJU	RY M 1		2   NO	28d. DE	SCRIBE HOW II	JURY OCCU	RED		
TTENDI CTOR: A after de 28 ls	ED	3 Suicide 8 Coul 4 Nomicide detail	ld not be irmined	28e. PLACE O building,	F INJURY atc. (Spec	— At home,	, farm, str	eet, factory, of	ffice		28f. LOC City	CATION (Street e or Town, State)	nd Number or	Rurel Route Number,		
로 로 전 ==	COMPLET			IAN: To the best of a										ceuse(s) end menner es stated.		
TO THE HOSPI TO THE FUNER be filed within	BE	SIGNATURE AND TITLE OF	zn			29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day,					SIGNED (Month, Day, Year)					
5	10	WILLAM	F. C	MHAC					65	BENCH	FRI	C7 all A	ICS V	no 20736		
		MAY U 5 1995	fulu	P. REGISTRA	_	ATURE				-10		,	0-,7			



BALTIMORE, MARYLAND 21215-0020

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ITEMS: 2. 4. 19b, PER DR./F.H. FILM G-724 6/12/95-95 134 2 Items#24.25.26.G-film 723 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH DAY 28 Shirley FRanklin April 1995 2:45 A.M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) B. BIRTHPLACE (State or Foreign IF UNDER I YEAR IF UNDER 24 HRS. 219 - 218 - 28 - 8953HOURS 1 M 2 NX DAYE 62 YRS. 6-20-32 MD 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 1639 Woodbourne Baltimore n/a RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY n/a Baltimore XX YES 2 NO 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1639 Woodbourne 21239 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES \$ NO IF YES, GIVE WAR OR OATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married 1 TES 2 TO Specify: 3X Widowed 4 Divorced Specify: Black 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY ntary/Secondary (0-12) College (1-4 or 5+) Day CAre Provider Child Care 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) George PAge Ruth HA11 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Keys 7 21133 9714 Liberty Rd. BAlto., MD -2120 20s. METHOD OF DISPOSITION
1/L/Burlal 2 Cremation 3 Removal from State 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of Garrison Forest 4 Donation 6 Other (Specify) 5/3 Owings Mills, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY James_A. MOrton & Sons FuneralHome 1701 Laurens St. Balto., MD 21217 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition_ cancer un 18 months reaulting in death)

DUE TO (OR AS A COMEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algorificent conditions contributing to death but not resulting in the undarlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 TES 2 7 NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 D Nursing Home 5 D Rasidence 8 D Other (Specify) 27. MANNER OF DEATH 26s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending 1 YES 2 NO

26s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

1 CERTIFYINO PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and placa, and due to the cause(s) and menner as stated.

other traumatic event, the CERTIFICATION injury, MEDICAL any Shows ? PHYSICIAN: 23 6 marked, BY .00 ED 28 COMPLET

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2 Accident 3 Suicide

4 Homicide

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After death

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TO THE HOSPITAL O TO THE FUNERAL D be filed within 72 ho IMPORTANT: If its

The certificate I

OR ATTENDING PHYSICIAN:

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29d. DATE SIONED (Mofith, Day, Year)

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

of Maryland Cancer Center. THE SHILL AND SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEET OF THE SHEE

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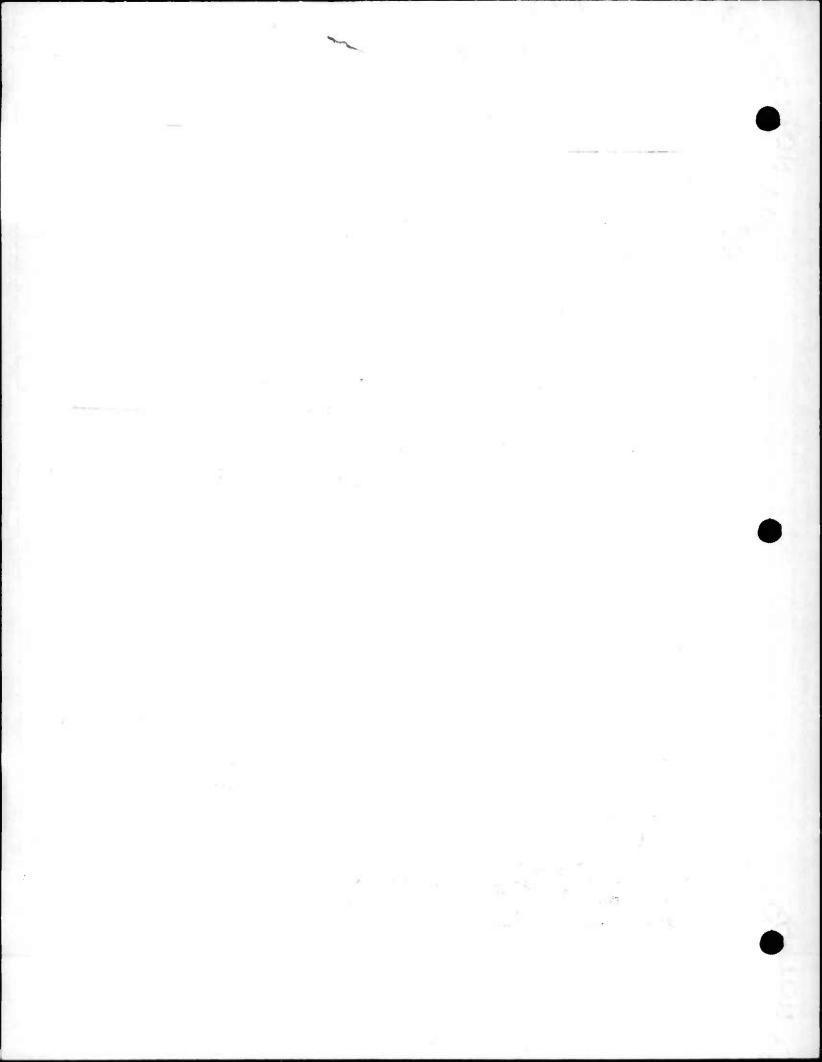
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29c. LICENSE NUMBER

DIVISION OF VITAL RECORDS, P.O. BOX 68760



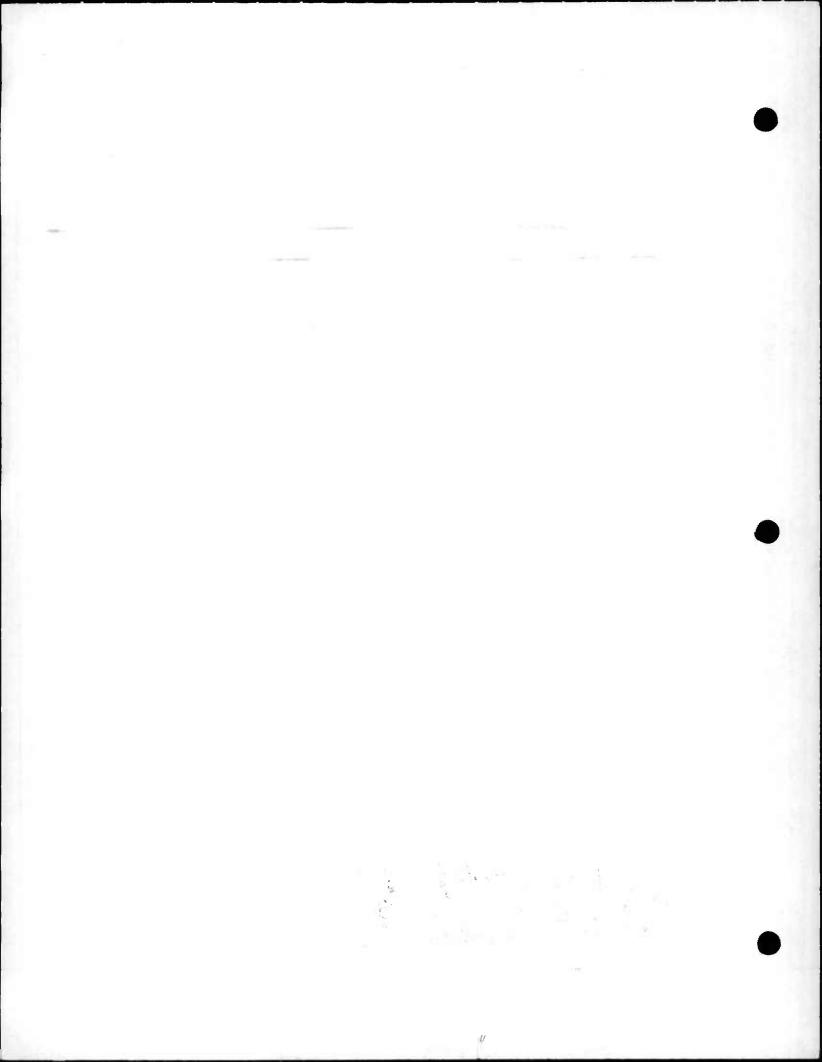
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within—of hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

	Items#10.c.10.d10.e.10.f G-film 723 per F.H 5/5/95 P.C 10.b												
	1 - STATE STATE OF MARTLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.												
	1. DECEDENT'S NAME (First, Middle, Last)				7 7				2. DAT	OF DEATH	·		3. TIME OF DEATH
	Paul Richard GU	CKENBERGI	ΞR						Apr	il 29,	1995	YEAR	3:07P M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la	st birthday)	IF UNDER 1	1 YEAR	IF UNDE	R 24 HRS.	7. DATE	OF BIRTH		8. BIRTH	PLACE (State or Foreign
	218-38-3424	1 🔀 M 2 🗌 F	54	YRS.	MONTHS	DAYS	HOURS	MIN.		th, Day, Year)	040	Country	V)
	9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY,	TOWN O	R LOCAT	ION OF D		, 1		MTY OF D	ryland
	Perry Point V.A	. Medica	Center					oint			1		
DIRECTOR	RESIDENCE OF DECEDENT	· Hearea.	i denter			TCII	. y 1	OIIIC				Ceci	.1
RE	10e. STATE 10b. COUNT	•		10c. CIT	Y, TOWN OF	R LOCATI	ON						10d. INSIDE CITY
	Maryland Ha	rford			S	tree	t	В	alt	imore			1 VES 2-NO
A	10e. STREET AND NUMBER 1 100	Walker	Ave.			10f.	ZIP COO	E			10g. CITI	ZEN OF W	/HAT COUNTRY?
量	-1385 Macton Road 21154 21239 U.S.A								Α.				
FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN	TEVER IN U.S. AF	MED	13. W	AS DECE	NOENT (	OF HISPAI	VIC ORIGI	N? (Specify Yes	or No-	14. RACE	- American Indian,
BY I	1 Never Merried 2 Merried 3 Widowed 4 X Divorced	IF YES, GIVE	X YES 2 1	NO	1	Yes, spe	2 NO	Specif	m, Puerto y:	Rican, etc.)		Specif	, White, etc.
ED B		Vietnam											White
E	15. DECEDENT'S EDU (Specify only highest grade		(G	ive kind of	Work done de	CUPATION uring most	N t of worki	ng	16	b. KIND OF BU	SINESS/INC	USTRY	
Elementary/Secondary (0-12) College (1-4 or 5+)  A Porsonnol Management Space Tracking Station									Stations				
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H	Carl H. Guckenbe									en Gak			
2	Carl H. Guckenbe	(brothe	r) 19							ber, City or Tow		Code)	
		erger, Jr						l, St	tree	t, MD	2115	4	
	20a. METHOD OF DISPOSITION 1 Durial 2 Cremetion 3 Rem	oval from State	20b. PLACE	AND DATE	OF DISPOSIT	TION (Nam	ne of		1	1.00	CATION —	City or Tox	wn, State
	4 Donation 5 Other (Specify)  21. BIGNATURE OF FUNERAL SERVICE LIC		Loud	on Pa					5/:	3 <u>Ba</u>	ltimo	re,	Maryland
ш	21. BIGHATORE OF FUNERAL SERVICE CR	ZENSEE ()	Λ					SS OF FA		1 Homes	т.,		
	Kolient Wide	Mach	2 1	in .						Baltin			21226
П	23. PART I. Enter the diseases, or o	complications that	t caused the de	eth. Do r	not enter t	he mod	e of dy	ing, suc	h ss car	diac or respi	ratory srr	est.	21236
	shock, or heart failure. IMMEDIATE CAUSE (Finsi	List only one cas	ise on each line	<b>).</b>									Interval Between Onset and Death
	disesse or condition	Acute	Myocard	ial I	Infar	atio	n						Onset and Destin
	resulting in death)  a. Acute Myocardial Infarction  Due to (or as a consequence of):												
z	Sequentially list conditions . Huntington's Disease												
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	OUE TO	(OR AS A CONSE	DUENCE OF	F):								
8	cause. Enter UNDERLYING CAUSE (Disease or injury	6.											
틸	thet initiated events	DUE TO	(OR AS A CONSEC	DUENCE OF	F):								
18	resulting in death) LAST	d											
O	PART II. Other significent condition	e contributing to	death but not a	o o ultila a	In Africa 11 and								
S	and any any and any	- contributing to	destii but not i	esuiting	in the und	errying	cause (	given in	Part I.	24a. WAS AN PERFOR	AUTOPSY MED?		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDIC					<del></del>				_	1 🗌 YES 2	<b>X</b> NO		COMPLETION DF CAUSE OF DEATH?
Σ													1 TES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTI	RIBUTE TO CA					UNC	ERTAIN	4 D				
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF OEAT	OTHER:								
YS	1 TYES 2X NO	1X Inpatient 2		□ DOA	4 🗆 Nursir		5 🗆 Re	sidence	8 🗆 Othe	r (Specify)			
	27. MANNER OF DEATH  1 X Natural 5 Pending	28a. DATE OF (Month, D		26b. TIM INJ	E OF 2 URY	WOR	RY AT	_ [	28d. OE	SCRIBE HOW I	JURY OCC	URED	
B	2 Accident Investigation				М		S 2	NO					
	3 Suicide 6 Could not be	28e. PLACE O building,	F INJURY — At ho atc. (Specify)	me, farm, s	street, factor	y, offica			28f. LOC	ATION (Street e or Town, State)	nd Number	or Rural Ro	oute Number,
	1 Homicos detarmined												
COMPLETED	(Check only 1 CERTIFYING PHYSIC	CIAN: To the best of	my knowledge, de	ath occurre	d at the tim	ne, date e	nd place.	, end due	to the ca	use(e) end man	ner ee state	ıd.	
OM	one) 2 MEDICAL EXAMINE	R: On the basis of e	xamination and/or i	investigatio	n, In my opi	Inlon, des	ith occur	ed at the	time, date	end place, and	dua to the	e cause(s)	end manner ee stated.
EC	29b. SIGNATURE AND TITLE OF CERTIFIER		17	-		- T	29c. LICE	INSE NUM	MER		29d. DATE	SIGNED /	(Month, Day, Year)
@		Cam	Hun No	Man	M	01	D1	6608	3			4-29	
유	30. NAME AND AODRESS OF PERSON WHO	1 1	SE OF DEATH (ITE	W 27) (16g/m	Print)				_			- 25	-
	KAM-KEN LEUNG, M.		MC, PERI			PERI	RY F	OTNI	, Mr	2190	)2		
	31. OATE FILEO (Month, Day, Year)		R'S SIGNATURE				1	72111	, , , , ,	2170			
	MAY 0 5 1995 July Devotes Reales												

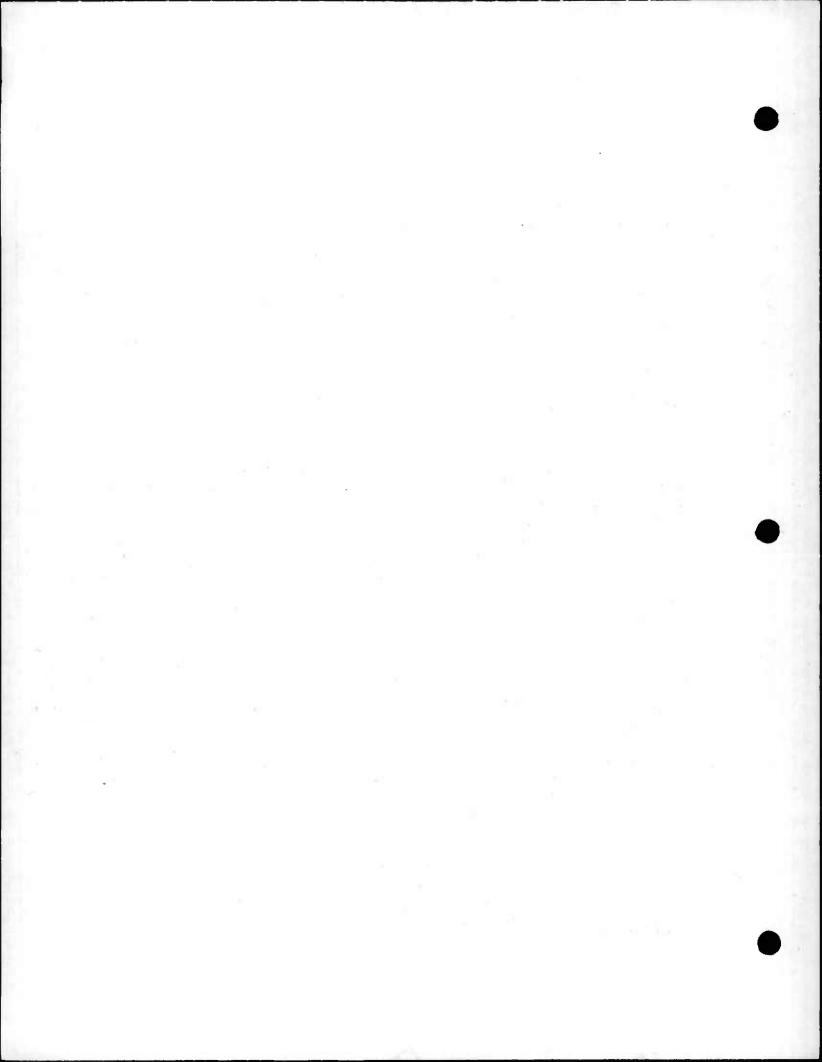




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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG NO 1. OECEDENT'S NAME (First, Middle, Leat) 2. DATE OF DEATH 3. TIME OF DEATH 03. MAY 1995 BETTY LEE GOMEZ 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) FEB.14,1936 5. SEX 6. AGE (In yrs. last birthday IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 N F DAYS HOURS 218-30-5422 59 BALTIMORE, MD. Pages 1, 2, 3 should 90. FACILITY NAME (If not institution, give 28 DANBEN COURT 96. CITY, TOWN OR LOCATION OF DEATH PERRY HALL BALTIMORE CO DIRECTOR RESIDENCE OF DECEDENT 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE CO PERRY HALL 1 TYES 2 X NO permit. FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 21236 28 DANBEN COURT funeral director, page 5 should be detached for use as the burial-transit hours after death. Page 6 may be retained by the hospital or attending physician, 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yee, specify Cuben, Mexicen, Puerlo Ricen, atc.) 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. If yee, specify Cube 1 Never Merried 2 Merried IF YES, GIVE WAR OR DATES Specify: WHITE BY 3 Widowed 4 Divorced Specify: COMPLETED 15. DECEDENT'S EDUCATION ecity only highest grade complet 16a. OECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) EX.OFFICER SOCIAL SECURITY ADMIN. 4 17. FATHER'S NAME (First, Middle, Leat) LEE ROY GRANER, SR. 18. MOTHER'S NAME (First, Middle, Maiden Symame)
HELEN GRACE LARKINS LEE म BE notified 190. INFORMANT'S NAME (Type/Print)
MR. MICHAEL J. GOMEZ 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 SOUTH COLLINGTON AVE. BALTIMORE, MARYLAND 21231 90 METHOO OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City of Town, State must 206. METHOD OF DISPOSITION

1 © Buriel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) COCKEYSVILLE, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE medical examiner JEFFREY L. GAIR 22. NAME AND AGORESS OF FACILITY LEONARD J. RUCK, INC. 5305 HARFORD ROAD BALTIMORE, MARYLAND 21214 completely filled in by the Lenter the disasses, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, shock, or heart fallure. Use only one cause on each line. Interval Batween IMMEDIATE CAUSE (Final Onset and Death other traumatic event, the disease or condition In alianar resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 If sny, leading to immediate cause. Enter UNDERLYING prior CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events the attending p resulting in death) LAST PART ii. Other significant conditions contributing to death but not reaulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS and AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? any signed the 1 | YES 2 | NO 1 YES 2 NO has been DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate t OTHER:
4 □ Nursing Home 5 □ Residence 8 □ Other (Specify) 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 27. MANNER OF DEATH 28s. OATE OF INJURY 28c, INJURY AT 28d, DESCRIBE HOW INJURY OCCURED this c marked, 1 Natural 1 YES 2 NO BY death 2 Accident Investigation 3 Sulcide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28 is 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be DIRECTOR: / COMPLETED 4 Homicide 29e. CERTIFIER (Check only one) TO THE HOSPITAL D
TO THE FUNERAL D
De filed within 72 ho
IMPORTANT: If IN bast of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner ee stated. ation end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Morth, Day, Year) 955 55 2 30. NAME, AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OGATH, (ITEM 27) (Type, Print) LARRY WATERBURY HOPKINS BAYULEW MED CENTER 31. DATE FILED (Month, Day, Year)
MAY 0 5 1995 32 REGISTRAR'S SIGNATURE



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

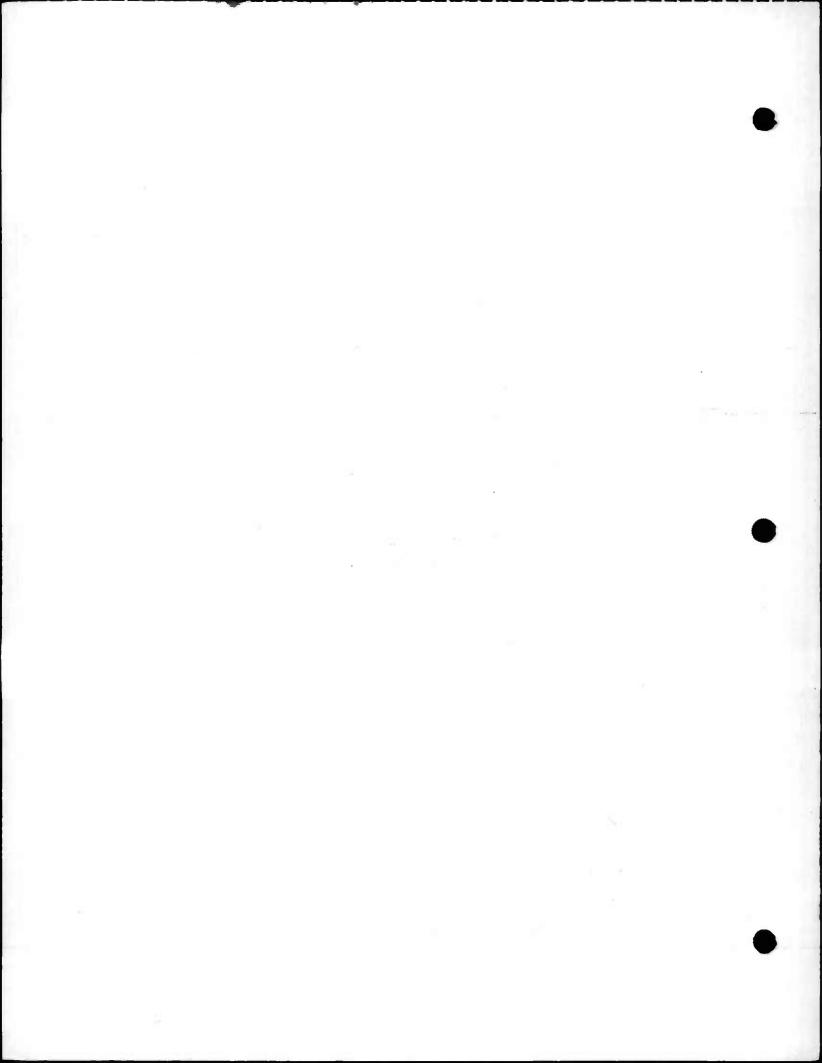
IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumattc event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.											
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATN		3. TIME OF DEATN				
	MILTON R. GORCZ	ZEWICZ				May 4	1995	02:30 a. M				
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE			IDER 24 HRS.	7 DATE OF BIRTH	0.5	BIRTNPLACE (State or Foreign				
	220-01-1177	1 XM 2 - F	74 YRS.	ONTHS DAYS HOU	RS MIN.	10/14/2(	) Ba	1timore, MD.				
	9a. FACILITY NAME (If not institution, give s			b. CITY, TOWN OR LO	ATION OF DE		9c, COUNTY					
OR	Fort Howard V.	A. Hospita	1	Fort Ho	oward		Balt	timore				
2	RESIDENCE OF DECEDENT  10a. STATE 10b. COUNTY	γ	Inc CITY	TOWN OR LOCATION								
SIR	Maryland	NA		ltimore				10d. INSIDE CITY LIMITS?  1 F YES 2 NO				
1	10e. STREET AND NUMBER			101. ZIP (	ODE		10g. CITIZEN OF WHAT					
ER/	Fait Avenue	6800			.224			J.S.A.				
FUNERAL DIRECTOR	11. MARITAL STATUS	12. WAS DECEDENT EVER				IC ORIGIN? (Specify Ye		RACE American Indian,				
ВУ Е	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1X YES	ATES	If yes, specify 0		n, Puerto Rican, atc.)		Black, Whita, atc. Specify:				
		1943 to						White				
IE	15. DECEDENT'S EDU (Specify only highest grade	completed)	16a. DECEDENT'S US (Give kind of wor life. Do NOT use	k done during most of w	orking	16b. KIND OF BU	SINESS/INDUST	RY				
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+) NA		reman		S+	eel	ì				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	1411			OTHER'S NAI	ME (First, Middle, Malden						
Ö	Stanley	Gorczewi	C 7		/icto			nkowski				
BE (	19a. INFORMANT'S NAME (Type/Print)	GOICZEWI				Noute Number, City or Tow						
5	Jerome C. Z.	iemski										
	20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION / Name of DATE 20c. LOCATION — City or Town. State											
	Sacred Heart Mary May8,1995 Dundalk, Maryland											
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	. 1	W. Dahr	PRESS OF FAC	i/Chojna	cki E	н р д				
	· Mark ( f	1/2000	b	1005 Dur	ndalk	Ave. Ba	1 to	Md. 21224				
12.5	23. PART I. Enter the diseases, Dr o	empiications that cause	d the death. Do not									
	shock, or heart failure.  IMMEDIATE CAUSE (Final	List Dnly ona cause Dn a	ach lina.					interval Betwean Oneat and Death				
	disease or condition a. Pulmonary Edema											
	DUE TO (OR AS A CONSEQUENCE OF):											
Z	Severe HYPERTENSION											
CERTIFICATION	Sequentially list conditions, if any, laading to immediata cause. Enter UNDERLYING											
5	CAUSE (Disease Dr injury	COUE TO (OR AS	CONSEQUENCE OF									
E	that initiated evants DUE TO (OR AS A CONSEQUENCE OF): reaulting in death) LAST											
		d										
정	PART ii. Other aignificant condition	s contributing to death b	out not resulting in	tha undarlying caus	a givan in i	Part i. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
						1 YES 2	(XNO	COMPLETION OF CAUSE OF DEATH?				
MEDI								1 - YES 2 X NO				
Ä	DID TOBACCO USE CONTI	RIBUTE TO CAUSE C			NCERTAIN							
C	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		THER:								
PHYSICIAN:	1 YES 2 NO  27. MANNER OF DEATN	1 The final state of the first term of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	28b, TIME (	Nursing Nome 5								
	1X Natural 5 Pending	(Month, Day, Year)	INJUR	Y WORK?		28d. DEŞCRIBE HOW I	NJURY OCCURE	0				
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY	— At home, ferm, atre		- 1	281. LOCATION (Street	and Number or Pr	umi Bouto Number				
	4 Nomicide  B Could not be determined	building, etc. (Spe	cify)	on, reactory, onice		City or Town, State)	IN NUMBER OF THE	urer House Number,				
COMPLETED	29a. CERTIFIER	CIAN: To the best of my beau	ladas danta assum d									
M		CIAN: To the best of my know R: On the basis of axamination						use/s) and manner as stated				
	29b. SIGNATURE AND TITLE OF CERTIFIER											
H	Proad	Into	111	29c. 1	LICENSE NUM	, / /	29d. DATE SIG	INED (Month, Day, Year)				
임	30. NAME AND ADDRESS OF PERSON WHI	D COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type. Pr	int)	4691	41	17/9	195				
	DR. NATARAJ, PR				ROAD	FORT HOUAT	D MAD	YLAND 21052				
	31. DATE FILED (Month, Day, Year)	, 32. REGISTRAR'S AIGN	ATURE		,,,,,,	TORT HOWAI	u, riak	TUMIND CIU)C				
- 1	MAY 0 5 1995 Juli d'avoler Rarlell											



BALTIMORE, MARYLAND 21215-0020

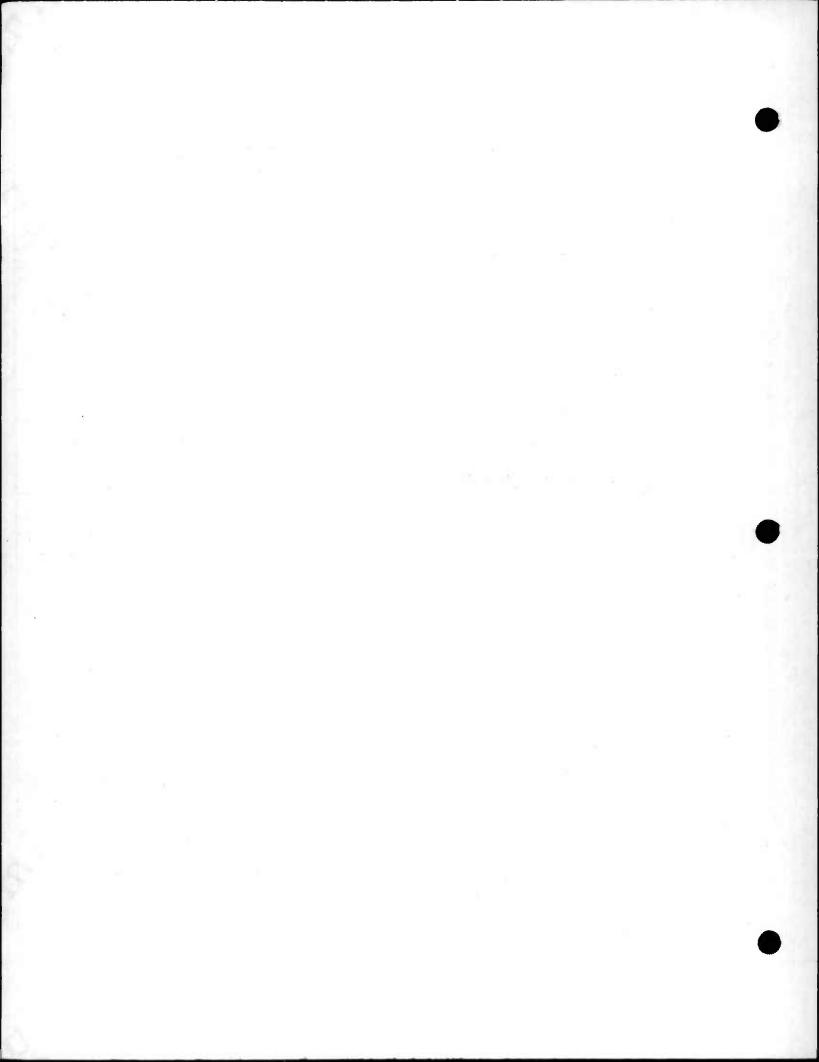
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 ELIZA GAINES MAy 12:00aM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birtnday) 7. DATE OF BIRTH (Month, Day, Year)
1.2-3-26 IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign DAYS 250-36-8092 HOURS 1 M M % T 69 YRS. Sc Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR n/a Johns Hopkins Bayview Medical Baltimore RESIDENCE OF DECEDENT 10b. COUNTY 10c CITY TOWN OR LOCATION 10d. INSIDE CITY MD Baltimore Turners Station permit. 1 TYES 2 TNO FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 553 New Pittsburg Ave. completely filled in by the funeral director, page 5 should be detached for use as the burial-transit ria, cremation, or removal. 21222 USA the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIYE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puarto Rican, atc.)

1 YES XXNO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married ZXMarried BY 3 Widowed 4 Divorced Specify: Black COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Home Maker 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Ed JAmes retained by Ħ BE Emma Rice notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Robert L. Gaines Sr. 553 New Pittsburg Ave. Balto., MD 21222 hours after death. Page 6 may be pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE must 1 Duriel 2 Cremation 3 R Cedar Hill 5/4 Baltimore, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons Funeral Home norton u ames 1701 Laurens St. Balto., MD 21217 medical 23. PARY i. Enter the diseasea, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate ahock, or heart fellure. List only one cause on each line Interval Retw IMMEDIATE CAUSE (Final Onset and Death the disease or condition Asystole UNKNOWN recuiting in death) event. DUE TO (OR AS A CONSEQUENCE OF): an and com executed Artem tisease traumatic nonaw CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate attending physician death certificate be prior cause. Enter UNDERLYING CAUSE (Disease or injury other Hygiene DUE TO (OR AS A CONSEQUENCE OF): thet initiated events reaulting in death) LAST 6 been signed by the atte Injury. PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. the 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? MEDICAL 24a. WAS AN AUTOPSY PERFORMED? that shows any 1 TYES 2 NO requires 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ PHYSICIAN: Dept. * 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) The item State certificate HOSPITAL OTHER: OR ATTENDING PHYSICIAN: 1 X YES 2 | NO Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Home 6 - Residence 6 - Other (Specify) the 6 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED marked. this c 1 Natural
2 Accident 5 Pending investigation M BY 1 YES 2 NO After the 26s. PLACE OF INJURY — A1 home, farm, street, factory, office building, stc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Floute Number, City or Town, State) .00 DIRECTOR: A hours after ditem 28 is ED 6 Could not be 4 Homicide COMPLET hours Hem 29e. CERTIFIER
(Chack only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and menner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 ho HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CENTIFIED BE 29¢ LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) luan 3706 MA 2 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) reeman Bay VIEW

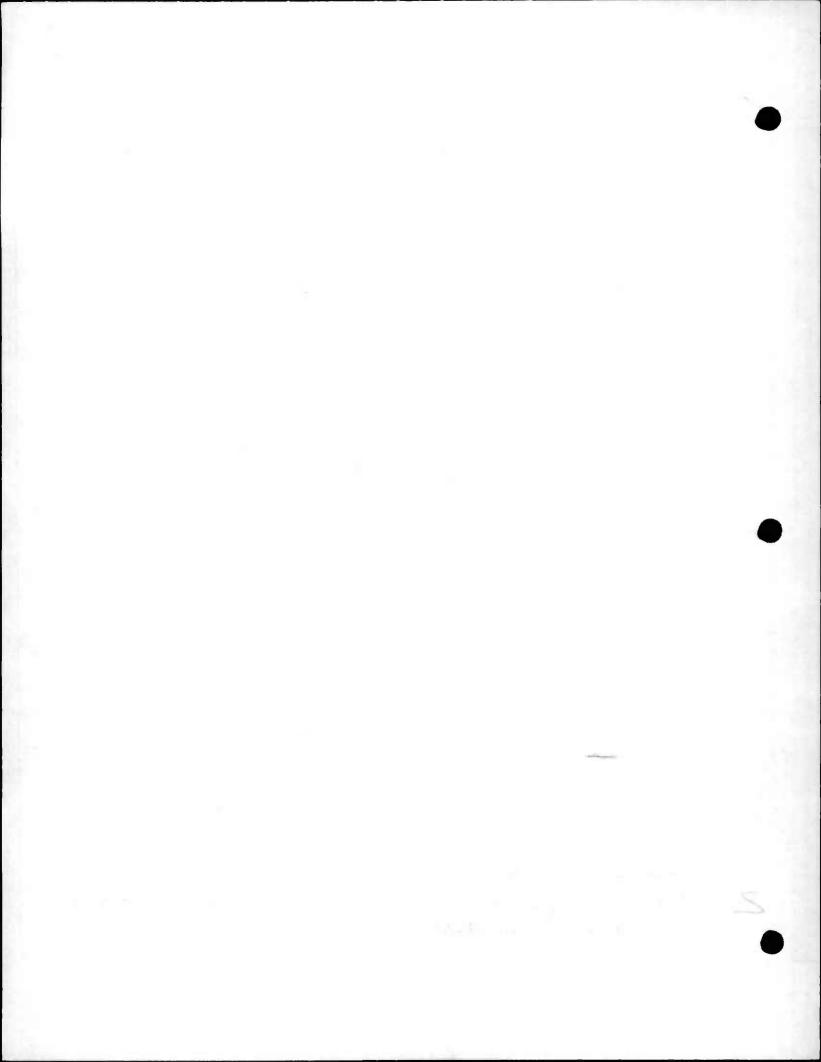
32. REGISTRAR'S SIGNATURE

31. DATE FILED (Month, Day, Year) MAY 0 5 1995



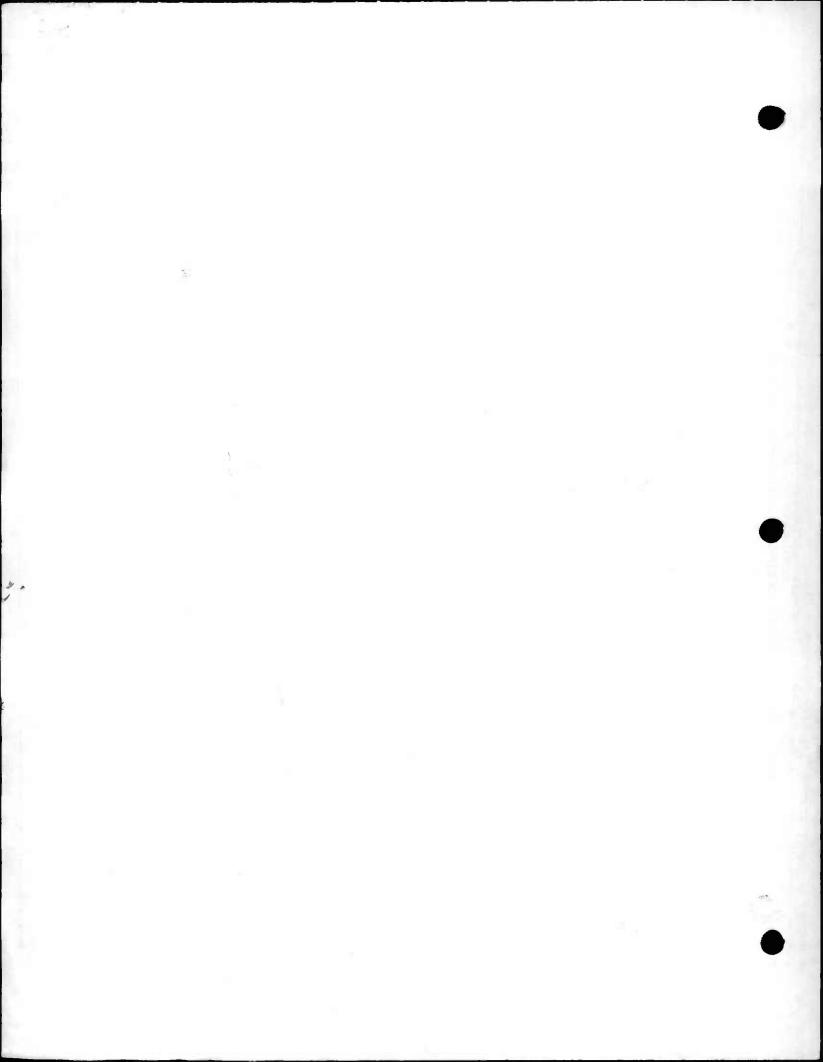
ITEMS: 23 PART I, 27,28a-f, PER MEO FILM G-723 5/12/95 t.t

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Ollie 1995 Lee Griffin May 02 0400 Jr 4. SOCIAL SECURITY NUMBER S. SEY 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) 4-20-IF UNDER 1 YEAR | IF UNDER 24 HRS. a. BIRTHPLACE (State or Foreign 46 -7169 1 M 2 D F MISSISSIDDI Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF BEATH DIRECTOR Edmondson Avenue Baltimore 10b. COUNTY 10c. CITY, TOWN OR LOCATION IOd. INSIDE CITY Baltimore 1 YES 2 NO permit. FUNERAL IN ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Edmondson S 10 3 21223 Ave funeral director, page 5 should be detached for use as the burial-transit hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married 1 TES 2 NO BY Specify: 3 Widowed 4 Divorced lack COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 7 aborer onstruction 17. FATHER'S NAME (First, Middle, Last) 100 BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Stre 2 10 21223 mondson 9 20a. METHOD OF DISPOSITION
1 Buriel 2 Separation 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must nation 3 🗆 R 4 Donation 5 Other (Specify) 4 1to., Md. cemator examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS A Mac ton Vames a Balta mes S St. Md. 21217 n by the fu 70 1 auren medical n and completely filled in by to burial, cremation, or remo 23. PART I. Infer the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, ick, or heart failure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final Onaat and Death the disease or condition resulting in death) NARCOTIC INTOXICATION event DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): executed traumatic CERTIFICATION Sequentially list conditions DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate that the death certificate be the attending physician Mental Hygiene prior to cause. Entar UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE n signed by the Health and N amy 1 ES 2 NO OF DEATH? Shows 1 YES 2 NO t. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN OR ATTENDING PHYSICIAN: The law has b 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) certificate h HOSPITAL: OTHER: TYES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA ng Home 5 Nesidence 8 Other (Specify) 6 28a. DATE OF INJURY (Month, Day, Year) FOUND 5/2/95 27. MANNER OF DEATH 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED After this c marked, 1 Natural М 1 YES UNKNOWN 3:50 A BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Soucifu) 3 Sulcide 261. LOCATION (Street end Number or Rural Route Number, City or Town, State) 1032 EDMONDSON AVE. 40 COMPLETED 6 Could not be DIRECTOR: hours after ( 4 Homicide 28 HOME Item 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner ee stated. TO THE FUNERAL OF TO THE FUNERAL DE FILED WITHIN 72 hr (Check only one) HOSPITAL ation and/or investigation, in my opinion, death occured at the time, date end pieca, and due to the ceuse(e) end menner as stated. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2 M 02 1995 COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HARYSMINS . VOREL LID 111 Penn Street, Baltimore, Maryland 21201 32. REGISTRAR'S DIGNATURE 05 1995

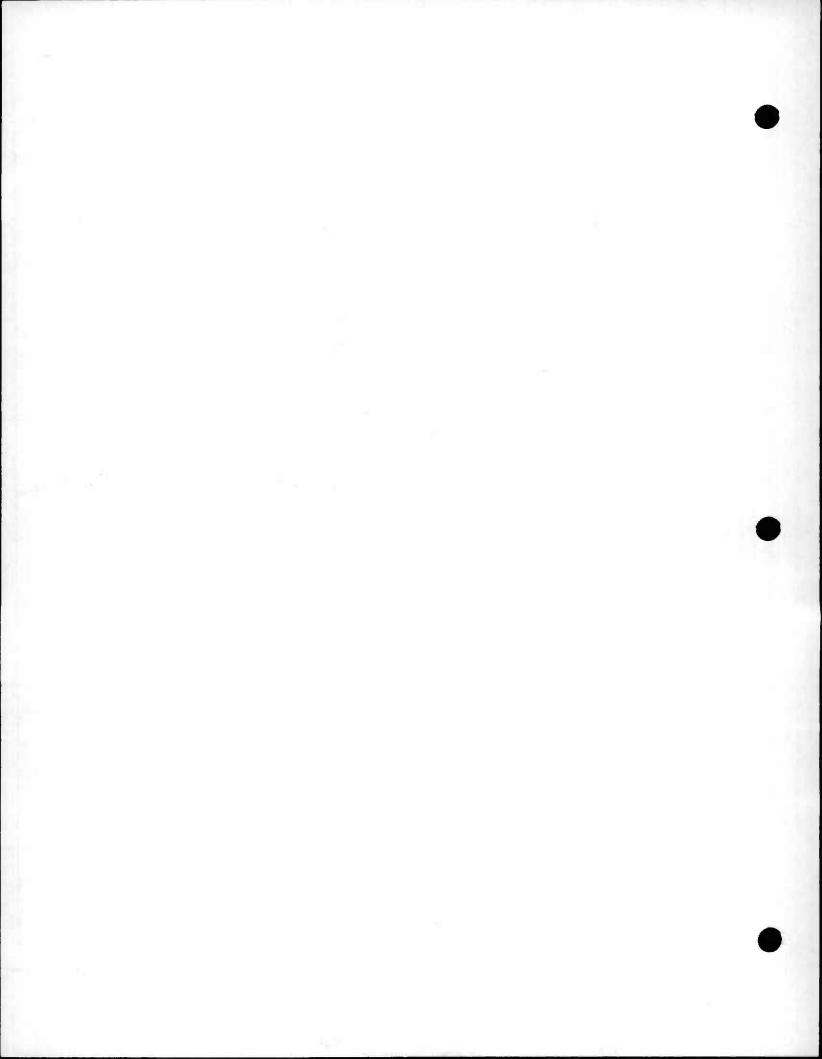


		FOR STATE REGISTRAR	STATE OF MARY		TMENT OF H			GIENE G. NO.				
		1. DECEDENT'S NAME (First, Middle, Last MARK		HALL			2. DATE OF DE	EATH DAY	YEAR 3.	TIME OF DEATH		
		4. SOCIAL SECURITY NUMBER					MAY	02 19	995	12:06 P		
		214-56-4656	1 - M 2 - E	(In yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BII (Month, Day.	Ybar)	Country)	ACE (State or Foreign		
3 should		9a. FACILITY NAME (If not institution, give	1	13 '''s	9b. CITY, TOWN (	OR LOCATION OF DE	3-16-		Mary	land		
∾"	TOR	1616 BRUCE COU	IRT		BALTI			st. 000N	nlx	7		
permit. Pages 1,	DIRECTOR	10a. STATE 10b. COUNT	n/A		y, town on Locate				7.0	d. INSIDE CITY LIMITS?  YES 2 NO		
	3AL	10a. STREET AND NUMBER				. ZIP CODE		10g. CITIZ		T COUNTRY?		
an. Iransit	FUNERAL	726 N. Colline	ton Ave.			21205		Ame	erica	à		
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit outfled at once.	BY FU	11. MARITAL STATUS  1 X Never Merried 2 Married  3 Widowed 4 Divorced	12. WAS DECEOENT EVER FORCES? 1 T YES IF YES, GIVE WAR OR D	IN U.S. ARMED 2 NO DATES	If yes, sp	ENDENT OF HISPANI ecity Cuban, Mexican 2 1 NO Specify:	i, Puerto Rican,	cify Yea or No— etc.)	Black, W Specify:			
215 attend se as	8	15. OECEDENT'S ED (Specify only highest grad			USUAL OCCUPATION		16b. KIND	OF BUSINESS/INDU	Blac	:K		
2121 tal or atte	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT us	work done during mo se retired.)	st of working						
AND the hospit detached	MP	10		Labor	er		Temr	orary a	igenc	.v		
MARYLAND retained by the hospit should be detached notified at once.		17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAM						
NRY and by ould t		Walter J. Hal.		Tob MAILING	1000000	Glads	ys Lun	n				
MAR retained 5 should										1. 21205		
AE, nay be page		Gladys Hall 20. METHOD OF DISPOSITION	20	b. PLACE AND OATE	OF DISPOSITION (Ne			20c. LOCATION — C				
AOR ge 6 ma rector, p		125 Buriel 2 Cremetion 3 Rer 4 Donation 5 Other (Specify)	noval from State	t. Zion	ther place)		1	Landsdo				
death. Page tuneral di		21. SIGNATURE OF FUNERAL SERVICE L	CENSEE		Derri	DADDRESS OF FAC	LODOG	Eunon-1	TI	-		
BALTIMORI ter death. Page 6 may the funeral director, p val.		Nevick 1	. Janes	7	4611	Park He	eiahts	Tuneral	HOM	е		
SALTIMORE, seconded within 24 hours after death. Page 6 may be and completely filled in by the funeral director, page o burial, cremation, or removal.  natic event, the medical examiner must be a		23. PART I. Enter the diseases, or ahock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)	COCAINE, MO	ech line.	ALCOHOL I			r respiratory arre	st,	Approximate interval Between Onset and Daath		
P.O. BOX 68 the certificate be executed physician and all Hygiene prior to bur or other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	cDUE TO (OR AS /	A CONSEQUENCE OF	7):							
RDS, at the dea by the at and Ment;	CAL	PART II. Other significent condition	ns contributing to death t	but not resulting i	n the underlying	cause given in F		WAS AN AUTOPSY PERFORMED?		RE AUTOPSY FINDINGS		
safth a	MEDIC						_ 10	YES 2 NO	COL	MPLETION OF CAUSE DEATH?		
RECOI requires that the signed is of Health a shows any		DID TODACCO LICE COAD	DIDLITE TO CALLES A		• =		_		10	YES 2 NO		
	3	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	KIBUTE TO CAUSE C	28. PLACE OF OEAT		UNCERTAIN						
VITAL  AN: The law tificate has e State Dep	SC	EXAMINER?  1  YES 2  NO	HOSPITAL:		OTHER:		TTo:			TENE		
NSICIA S certification the the	РНУ	27. MANNER OF DEATH	28s. DATE OF INJURY	FOUND		e 5 Residence 8		HOW INJURY OCCU		LEND		
ON OP DING PHYS After this o death with	ВУ Б	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year) FOUND: 5/2/9	5 11:3		RK? 'ES 2 (C)(NO	UNKNOWN					
TTENDI TTENDI TOR: A after d	ETED E	3 Suicide 8 XX Could not be 4 Homicide determined	28a. PLACE OF INJURY building, etc. (Spe-	Y — At home, farm, a city) HOU			28t. LOCATION City or Town	(Street and Number of State) 1616 B	Aural Poure	OR Por		
	APLE		ICIAN: To the best of my know									
HOSPITAL FUNERAL within 72	COMPL	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(a) and manner as atteted,										
TO THE HOSPITAL TO THE FUNERAL be filed within 72	BE	296. SIGNATURE AND TUTLE OF CERTIFIE	R W			29c. LICENSE NUME				rith, Day, Year)		
2 2 3 <b>X</b>	0	36. NAME AND ADDRESS OF PERSON WI	Myg 1	W		O.C.M.	E.	► MA	. у UЗ	,1995		
ACTIVE OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PART		THE 9006	1.1/1/			ET,BALTI	MORE	MA RVI. AN	ID 21	201		
		31. DÁTÉ FILEO (MORITI, Day, Your) M/V 0 5 1005	34 REGISTRAR SOIGN		. DIREI	II, DAUII		· WILL DAN	2 21	201		





		FOR STATE REGISTRAR	STATE OF MARYLAND / DI	EPARTMENT OF I	HEALTH AND	MENTAL HYGIE			
		1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH	1
		WILFORD	HUGGINS			May 3,	1995	5:50	a
should		4. SOCIAL SECURITY NUMBER  518-64-1002  9a. FACILITY NAME (If not institution, give a		YRS. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Mar)	19506	BIRTHPLACE (State or Fore Country)  UTh Caro	lin
63	S.		MORE MEDICAL CE		OR LOCATION OF $E$	EATH	9c. COUNTY	OF DEATH	
s 1, 2,	ЕСТОЯ	RESIDENCE OF DECEDENT					1 2		
permit. Pages	L DIR	Maryland 100. STREET AND NUMBER	N/A	Baltin	nore			10d. INSIDE CITY LIMITS? 1 PYES 2 N	10
150 150	NERA	11. MARITAL STATUS	e'Ave		2/20	/		S A	
	BY FUNI	1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. APMED FORCES? 1 YES 2 YNO IF YES, GIVE WAR OR DATES	if yes, so	pecify Cyban, Mexic S 2 NO Speci	NIC ORIGIN? (Specify Yan, Puerto Rican, etc.) fy:	18 or No — 14.	RACE — American Indian Black, White, etc.	ł,
afte afte	TED	15. DECEDENT'S EDU (Specify only highest grade	completed) (Give id	ENT'S USUAL OCCUPATE	ON ost of working	16b, KIND OF B	USINESS/INDUST	TRY	
Spital o	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	NOT use retired.) 15TOGIC	an	S	choc		
YLAN by the hor be detach at once.		17. FATHER'S NAME (First, Middle, Last)	(0)		18. MOTHER'S N	AME (First, Middle, Maide	Surname)	+	
MARY retained b 5 should to	BE	190. INFORMANT'S NAME (Type/Print)	19b. M/	AILINO ADDRESS (Street	and Number or Rural	Route Number City or To	Wn, State, Zip Coo	Se)	_
r, N y be re page 5	2	Mary Tugg 208. METHOD OF DISPOSITION	20bsPLACE AND	22 Myr	tle Av	e. Balt	TO, Ma	,21201	
2 0 0 E		1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	manufacture Const.	Sitem	Star	5/6/95 E	balta.	Ma.	
death fune		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	Jose Jose	NO ADDRESS OF E	YUSS FU	ineral	Hame	1/-
E 3 & a		23. PART   Enter the diseases, or o	complications that caused the death.	Do not antar tha mo	oda of dying, suc	ch se cardiac or resp	piratory srrest,		
		IMMEDIATE CAUSE (Final disease or condition	· ·					Onset and	
ted within 24 completely fille fal, cremation,		resulting in death)	DUE TO (OR AS A CONSEQUEN	ACE OF				3 day	2
8 0 8	_		AIDS	voe or j:				ļ	
a clan	CATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSEQUEN	ICE OF):					
ficat phy ne phy	RTIFIC	CAUSE (Disease or Injury that initiated events	OUE TO (OR AS A CONSEQUEN	ICE OF):					
L 5 5 0	- ш - п	resulting in death) LAST	ı						
The day	CAL C	PART II. Other aignificant condition	contributing to death but not resul	Iting in the underlyin	g cause given in			24b. WERE AUTOPSY FING	
_ & a a ≥	MEDIC					1 TYES	2 1140	AMAILABLE PRIOR TO COMPLETION OF CAI OF DEATH?	
ATENDING PHYSICIAN: The law requires the ECOR: After this certificate has been signed is after deah with the State Dept. of Health is 128 is marked, or litem 23 shows am	1	DID TOBACCO USE CONTI	RIBUTE TO CAUSE OF DEATH	YES II NO I	UNCERTAI	N IZ	10	1 TES 2 NO	>
V: The law icate has be State Dept.	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF	DEATH (Check only one)		N LD		-	_
SICIAN: The lar certificate has the State Dep 1, or Item 23	YSIC	1 TYES 2 NO	HOSPITAL: 1 Inpetient 2 I ER/Outpetient 3 I I	OTHER: 4   Nursing Horr	ne 5 🗆 Rasidence	6 Other (Specify)			
NG PHYSIC feer this ce sath with ti	РНҮ	27. MANNER OF DEATH  1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	INJURY WO	JURY AT ORK?	28d. OEŞCRIBE HOW	INJURY OCCURE	.D	
After death death	D BY	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY — Al homa, 1		YES 2 NO	28f. LOCATION (Street	and Number or B	lural Bouta Number	
L OR ATTENDING P DIRECTOR: After the hours after death	H.	4 Homicide detarmined	building, etc. (Specify)			City or Town, State	)	pres riogie rearribes,	
AL OR A AL DIREC 2 hours 1 item	COMPLETE		NAM: To the best of my knowledge, death o						
THE HOSPITAL THE FUNERAL filed within 72 h	S S		R: On the basis of examination and/or inves	tigation, in my opinion, d	leath occured at the	time, data and place, a	nd due to the car	use(s) and manner as stat	led.
世 半 温 を	B	200/ SIGNATURE AND TITLE OF CERTIFIER	ele my		29c. LICENSE NU D 439	MBER 3 (c	29d. DATE SIG	3 95	
E 69 8	2	40		(Type, Print)	7 171		1 31	3/45	
1		30. NAME AND ADDRESS OF PERSON WHO THOMAS F. LAN!	DALE II M.D. G	565 N. C	haules 5	t., Balton	or ME	> 21204	
5		MAY U 5 1995	32. REGISTRAR'S GIGNATURE						

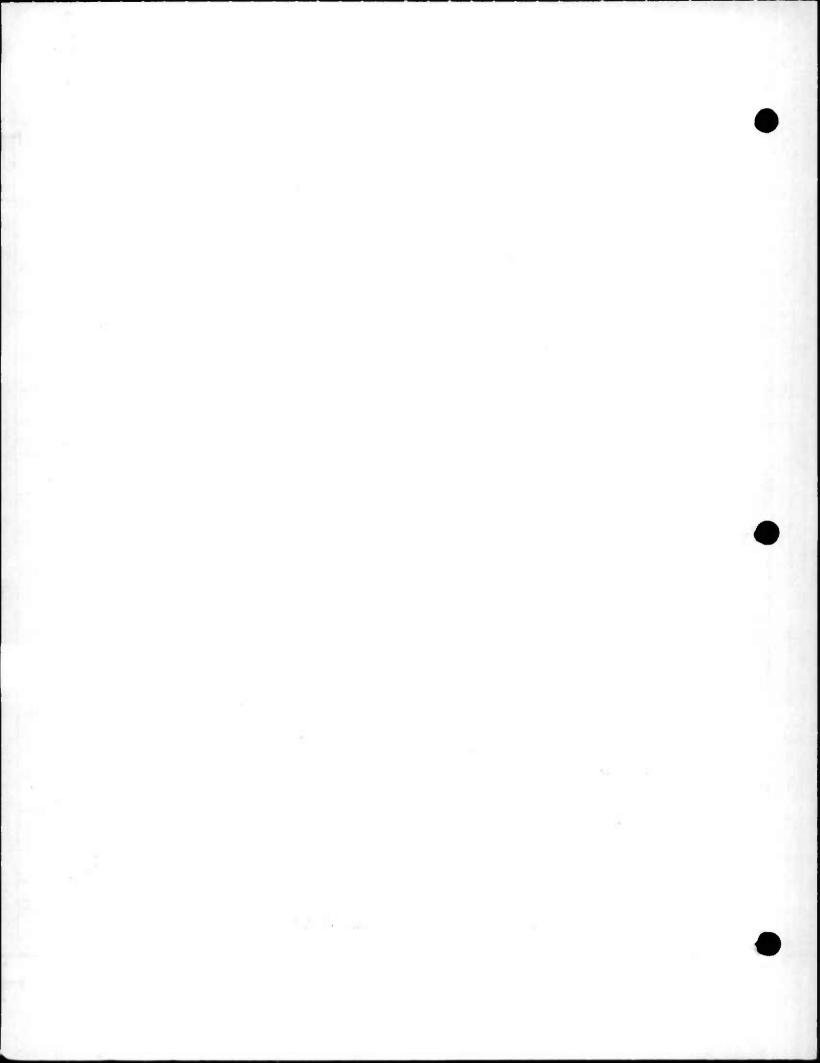


BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

31. OATE FILED (Month, Day, Year)

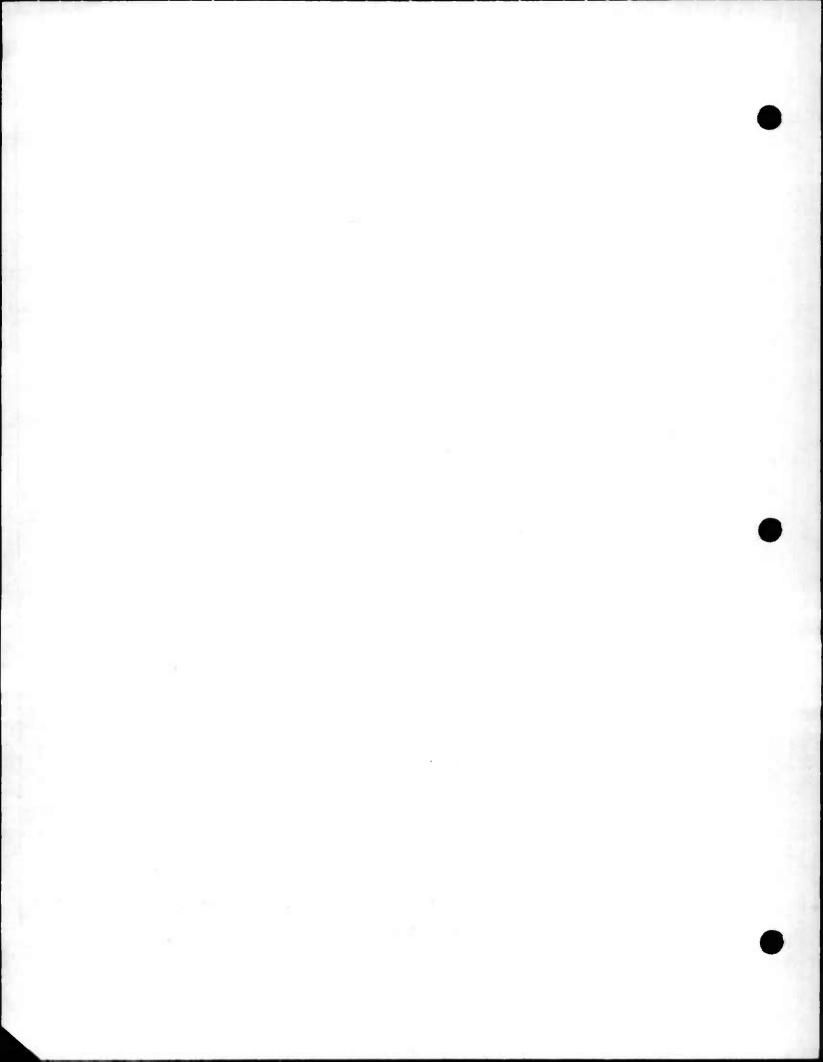
		30 10420
	1 - FOR STATE OF MARYLAND / DEPARTMENT OF H	DEATH
	1. DECEDENT'S NAME (First, Middle, Last) MARY HICKMAN	2. DATE OF DEATH MAY 03 1995 3. TIME OF DEATH 12:05 A
<u>P</u>	4. SOCIAL SECURITY NUMBER  5. SEX  1  M 2  F  8. AGE (In yrs. lest birthday)  F UNDER 1 YEAR  MONTHS  DAYS	FUNDER 24 HRS. HOURS MIN.  7. DATE OF BIRTH Morth, Dey, Year) MAT, 22, 1906 NOTH CATOLINE
2, 3 shou		SVILLE 9c. COUNTY OF GEATH BALTIMORE
burial-transit permit. Pages 1, 2, 3 should	10g. STATE 10b. COUNTY N/A 10c. CITY, TOWN OR LOCATE BOX 1.00	10d. INSIDE CITY LIMITS?  1 1 Yes 2   NO
ansit perm	10s. STREET AND NUMBER 101.	ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?
detached for use as the burial-transit once.	11. MARITAL STATUS  1 Never Married 2 Married  3 Widowed 4 Divorced  12. WAS DECEDENT EVER IN U.S. ARMÉD FORCES? 1 YES 2 NO If yes, spe If YES, GIVE WAR OR DATES  13. WAS DECEDENT EVER IN U.S. ARMÉD If yes, spe If Yes, GIVE WAR OR DATES  13. WAS DECEDENT EVER IN U.S. ARMÉD If yes, spe If Yes, GIVE WAR OR DATES  14. WAS DECEDENT EVER IN U.S. ARMÉD If yes, spe If Yes, GIVE WAR OR DATES	ENDENT OF HISPANIC ORIGIN? (Specify Yes or No
for use as t	15. DECEDENT'S EOUCATION (Specify only highest grade completed)  Elementapy/Secondary (0-12)  Collage (1-4 or 5 +)  Ital. DECEDENT'S USUAL OCCUPATION (Give kind of work done during mos	IN 18b. KIND OF BUSINESS/INDUSTRY
once.	12 FATHER'S NAME (FIRST, MICHOLO, LOSS)	Ker Own Home
e notified at	TOBETT Shaver  190. INFORMANT'S NAME (Type/Print)  19b. MAILING ADDRESS (Street or	Mary Jane Shaver  Ind Number or Rubil Route Number, City or Towg, State, Zip Cogle)
must be no	20s. METHOD OF DISPOSITION  1 56 Burlel 2 Cremetion 3 Removal from State  20b. PLACE AND DATE OF DISPOSITION (New Cometery, organizery of other place)	a SKi St. Balto, Md, 21217  DATE 20c. LOCATION - City of Town, State
₩ m	4 Donation 5 Other (Specify)	Opposess of Facility  Con Man
or removal.  medical examin	23. PART . Enter the dispesse, or complications that coused the deeth. Do not enter the mode	2 W. North Ave, Balto, Md, 21216 de of dying, auch aa cardiec or respiratory arrest, Approximete
completely filled in ial, cremation, or r. sevent, the mec	MANDIATE CAUSE (Since)	clepatic Cache mach Deserve
9 's	Sequentially list conditions, if any, leeding to immediate  b. Due TO (OR AS A CONSEQUENCE OF):	
\$ 5 P	CAUSE (Disease or injury that initiated events OUE TO (OR AS A CONSEQUENCE OF):	
0 9 3	PART II. Other algorificent conditions contributing to death but not resulting in the underlying	Course where to Book I are a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second and a second a second and a second and a second and a second and a second and a second and a second and a second and a second and a second a second and a second and a second and a second and a second and
signed b lealth ar		Couse given in Part I. 24a, WAS AN AUTOPSY PERFORMED? 24b, WERE AUTOPSY FINOINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)	UNCERTAIN LA CONCENTION 1 YES 2 NO
vith the State Dept. or Item 23 s. PHYSICIAN:	EXAMINER?  HOSPITAL: 1   Inpetient 2   ER/Outpetient 3   DOA   4   Nursing Home	5   Residence 6   Other (Specify)
= > =	2 Accident	RK? ES 2 □ NO
HECTOR:	3 Suicide s Could not be determined 28e. PLACE OF INJURY — At home, term, street, tectory, office building, stc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
M = 25	(Check only one)  2 MEDICAL EXAMINER: On the beels of examination and/or investigation, in my opinion, de	
TO THE FUNE be filed within IMPORTANT: TO BE COI	296. SIGNATURE AND TITLE OF CERTIFIER Theodore M. King mo	O.C.M.E.  29d. DATE SIGNED (Month, Day, Year)  may 03, 1995
, [	30. NAME AND ADDRESS OF PERSON WHO COMPLETED LAUSE OF DEATH (ITEM 27) (Type, Print)  THE IDORE Mc King 1111 Penn Stree	t, Baltimore, Maryland 21201

		1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF I		MENTAL	HYGIENI	E		
		1. DECEDENT'S NAME (First, Middle, Last)			10/112 0.	D-1271.11	2. DATE	OF DEATH		3. 1	TIME OF DEATH
		JESSIE  4. SOCIAL SECURITY NUMBER	T T	WKINS	7		May	2	, 199	5	11:04 PM
		217-12-6256	5. SEX 6. AGE (II	n yrs. lest birthday) YRS.	MONTHS DAYS	HOURS MIN.		OF BIRTH , Day, Year) 1 Q 1		Country)	CE (State or Foreign
3 should		9a. FACILITY NAME (If not institution, give a			9b. CITY, TOWN	OR LOCATION OF D		19, 1	913 Ne		ersey
1, 2,	СТОВ	1344 Washington	Street		Baltim	ore				n/a	
oit. Pages	DIRE	10e. STATE 10b. COUNT	n/a		Y, TOWN OR LOCA altimore					LINSIDE CITY LIMITS?  YES 2 \[ \] NO	
t permit.	FUNERAL	10e. STREET AND NUMBER			10	f. ZIP CODE			10g. CITIZEN	OF WHAT	COUNTRY?
020 physician. burial-transit	JNE	1344 Washington S	12. WAS DECEDENT EVER IN	U.S. ARMEO	13 WAS DEC	21213	MIC OBIGIN	2 (Specify Yea		S.A.	
o g e	BY	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 TYES IF YES, GIVE WAR OR DA	2 XNO	If yes, sp	ecity Cuben, Mexic	xican, Puerto Rican, etc.) Blac				American Indian, life, atc.  Black
	TED	15. DECEOENT'S EDU (Specify only highest grade	completed) (Give kind of work done during most of working				16b.	KIND OF BUS	INESS/INDUST		
	PLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Dome	se retired.)	•		in	own h	ome	
LAND the hospit detached	COMPL	17. FATHER'S NAME (First, Middle, Last)		3010	AME (First, M	fiddle, Maiden S		ome			
3YL d by ti d be	BEC	Bedford Blue				Judy Wa	shing	ton			
MARYLAND retained by the hospit 5 should be detached notified at once.	0	19a. INFORMANT'S NAME (Type/Print)				and Number or Rural					
		Mary Rich	206		N. Durhai	m Street	/Balt		MD 2]		20-4-
MOR age 6 ma director, p		1 Buriel 2 ☐ Cremetion 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State carrie	elery, cremetory or o	ther place)		5-5-95				1 Co.MD
ALTIM death. Page huneral dire examiner n		21. SIGNATURE OF FUNERAL SERVICE LIC			22. NAME AI	Funeral	ACILITY		IC AL	unde	1 CO PID
		1-	-XA	5	1101	E. North	Aven	ue/Bal	timore	, MD	21202
filled in tion, or re		23. PART i. Enter the diseases, or shock, or heert failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)	A	the death. Do	not anter tha mo	ede of dying, aud	ch ea csrd	lec or respir	atory errest,		Approximate interval Between Onset and Death
P 0 0 4 0			OUE TO (OR AS A	CONSEQUENCE O	F):						
and o bur	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE O	F):						
B P at a	FIC	CAUSE (Disease or injury that initiated events	C. DUE TO (OR AS A	CONSEQUENCE O	F):						
, P.O. E eath certifica attending ph ntal Hygiene y, or other	ERT	resulting in dasth) LAST									
이 의 목도 등		PART II. Other algnificant condition	a contributing to death bu	it not resulting	in the underlying	g cause given in	Part i.	24a. WAS AN A	NUTOPSY	24b. WEF	E AUTOPSY FINDINGS
AL RECORI  The law requires that the has been signed by it begit, of Health and an 23 shows any in	MEDICAL	-		_			_	PERFORM		OF E	LABLE PRIOR TO IPLETION DF CAUSE DEATH?
- D -		DID TOBACCO USE CONT	RIBUTE TO CAUSE OF	F DEATH YE	S   NO	UNCERTAI	N 🖸			1	YES 2 NO
OF VITAL PHYSICIAN: The law this certificate has the with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the State Dept with the Stat	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINENT?			TH (Check only one)						
OF VITA PHYSICIAN: The this certificate ha with the State D rked, or item	IYSI	1 FES 2 NO	1 - Inpetient 2 - ER/Oulpe			e 5 Residence					
	ву РНУ	1 Natural 5 Pending 2 Accident Investigation	28e. OATE OF INJURY (Month, Day, Year)	26b. TIM		PRK?	26d. DES	CRIBE HOW IN	JURY OCCURE	iD.	
ISIC TTENDI TOR: A after d	ETED B	3 Suicide 6 Could not be detarmined	28e. PLACE OF INJURY building, etc. (Specific	At home, ferm,	streat, fectory, offic	•	261. LOCA City o	TION (Street ar r Town, State)	nd Number or R	ural Route	Number,
DIV L OR A L DIREC 2 hours I Item	PLE	29e. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the beat of my knowle	edge, death occum	ed at the time, data	end place, end due	e to the ceus	e(a) end menr	ner as stated.		
TO THE HOSPITAL TO THE FUNERAL De filed within 72 h	COMPL	one) 2 MEDICAL EXAMINE	R: On the besis of examination	and/or investigation	on, in my opinion, d	leath occured at the	time, date	end place, end	dus to the ce	use(s) and	manner as stated,
TO THE HOSPIT TO THE FUNERA DE filed within 7	BE (	29b. SIGNATURE AND TITLE OF CERTIFIED				29c. LICENSE NU	MBER		29d. OATE SIG	NED (Mon	th, Day, Year)
₽ ₽ 3 <b>X</b>	2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DEA	TH (ITEM 27) /Type	Delet	D45982			5	141	25
4		Augani Vi	32. REGISTRAP'S SIGNAL AND STREET	O E N	LONUME	2- 706	7	BA	-T, 1	10	21205
'		5 (4(95	MAY 0 5 1995	Julia 6	Okudsor Re	roball			1		



	MEN												
7.	УW	pe	r	f	h	9	5		3	1	2	2	

		1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	RTMENT	OF H	EALTH DEAT	AND MI	ENTAL HYGIEI			
		1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH		YEAR 3. 1	TIME OF DEATH
		ELLA  4. SOCIAL SECURITY NUMBER	MAF 5. SEX 8. AGE (In		GGIN			$\rightarrow$	MAY 02	1995		16:24 PM
pin		213-22-7201	1□ M 2 X F 67	yrs. last birthday) YRS.	IF UNDER 1	DAYS	HOURS	MIN.		1928	MARYL	
1, 2, 3 should	TOR	94. FACILITY NAME (If not institution, give some state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of					MORE		·H		n/a	1
Pages	DIRECTO	MARYLAND 106. COUNT	n/a	10c. C/1	CHA	R LOCAT		TIMOR	RE		I X	I. INSIDE CITY LIMITS? YES 2 NO
ın. ransit permit.	FUNERAL	100, STREET AND NUMBER 2403 E. CHASE	STREET			10f	ZIP CODE 212			UNI	TED S	STATES
21215-0020 al or attending physician. for use as the burial-transit	ВҰ	11. MARITAL STATUS 1 Never Merried 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN L FORCES? 1 YES IF YES, GIVE WAR OR DATE	2XXNO	tr.	yes, sp	ENDENT OF ecity Cuben, 2 XXNO	HISPANIC Mexican, I Specify:	ORIGIN7 (Specify Yo Puarlo Rican, atc.)	es or No— 1	Black, Wh	American Indian, nite, atc. BLACK
21 10 m	PLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION 1 completed)  College (1-4 or 5+)	6a. DECEDENT'S (Give kind of life. Do NOT u.	work done di			7	166. KIND OF BUSINESS/INDUSTRY HOMEMAKER			
YLAND by the hospital be detached to at once.	E COMPL	17. FATHER'S NAME (First, Middle, Last)	ESTER				18. MOTH	HER'S NAME (First, Middle, Meiden Surmeme) EMMA				
MAR retained 5 should notified	TO B	190. INFORMANT'S NAME (Type/Print)  JAMES HAGG	INS	196. MAILING 241	ADDRESS 03 E	(Street a	nd Number of CHASE	or Runal Rou	rte Number, City or Tox	wn, State, Zip C	iode) E. MAF	RYLAND#13
ALTIMORE, leath. Page 6 may be furneral director, page xaminer must be		20e. METHOD OF DISPOSITION 1	oval from State 20b.P	LACE AND DATE	OF DISPOSIT	TION (Na	me of		DATE 20c. LO	OCATION — CH	ty or Town, S	State
		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE //	, Te			C. MA	S OF FACIL				AVENUE
760 B, did within Z4 hours after ompletely filled in by the cremation, or removal event, the medical		23. PART I. Enter the disesses, or shock, or heart failure.  IMMEDIATE CAUSE (Final disease or condition resulting in death)	complications that caused to List only one cause on each section.  Due to (on as a complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to the complete to	n line.	Cord				as cardiac or reap	piratory arres	pt,	Approximata Interval Between Onset and Death
o. C. BOX 68 certificate be execute nding physician and or Hygiene prior to buria or other traumatic	ERTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A C	ONSEQUENCE O	F):							
RDS, F nat the death by the atter and Mental y injury, o	O	PART II. Other algnificant condition	a contributing to death but	not resulting	In the und	lariying	ı cause gi	ven in Pa	rt I. 24s. WAS AF			RE AUTOPSY FINDINGS
RECO v requires the been signed t, of Health shows an	N: MEDICAL	DID TOBACCO USE CONT	RIBUTE TO CAUSE OF	DEATH YE	S 🗆 N	10 🗆	UNCE	RTAIN	TX YES	2 1 NO Parly	OF E	PLETION OF CAUSE DEATH? YES 2 NO
//TAL. N: The lav ficate has State Dep	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	PLACE OF DEA	OTHER:							
or the	1YS	1X YES 2 NO  27. MANNER OF DEATH	1 Inpetient 2 X ER/Outpati	ent 3 DOA	4 🗆 Nursi	ng Home		-	Other (Specify)			
SION OF	BY P	1 Accident 5 Pending Investigation	(Month, Day, Year)	LNI	M		RK7 ES 2	NO	Bd. DESCRIBE HOW			
N ATTEN RECTOR: Jus after m 28 la	ETED	3 Suicide 8 Could not be determined	28s. PLACE OF INJURY — building, atc. (Specify)						Bf. LOCATION (Street City or Town, State	)		Number,
로 그	COMPLET	(Check only 1 CERTIFYING PHYSI	CIAN: To the best of my knowled R: On the besis of examination a									manner as stated,
TO THE HOSPIT TO THE FUNERA DE filed within 7	8	29b. SIGNATURE AND TITLE OF CERTIFIES	y tend u	1.1	-			OCME			SIGNED (Mon	th, Day, Year) 1995
	2	30. MAGNE AND ADDRESS OF PERSON WH										
5		31. DATÉ FELED (Month, Day, Year)	39. REGISTRAR'S SIGNATI		enn S	Str	eet,	Bal	timore	Mary	yland	1 21201



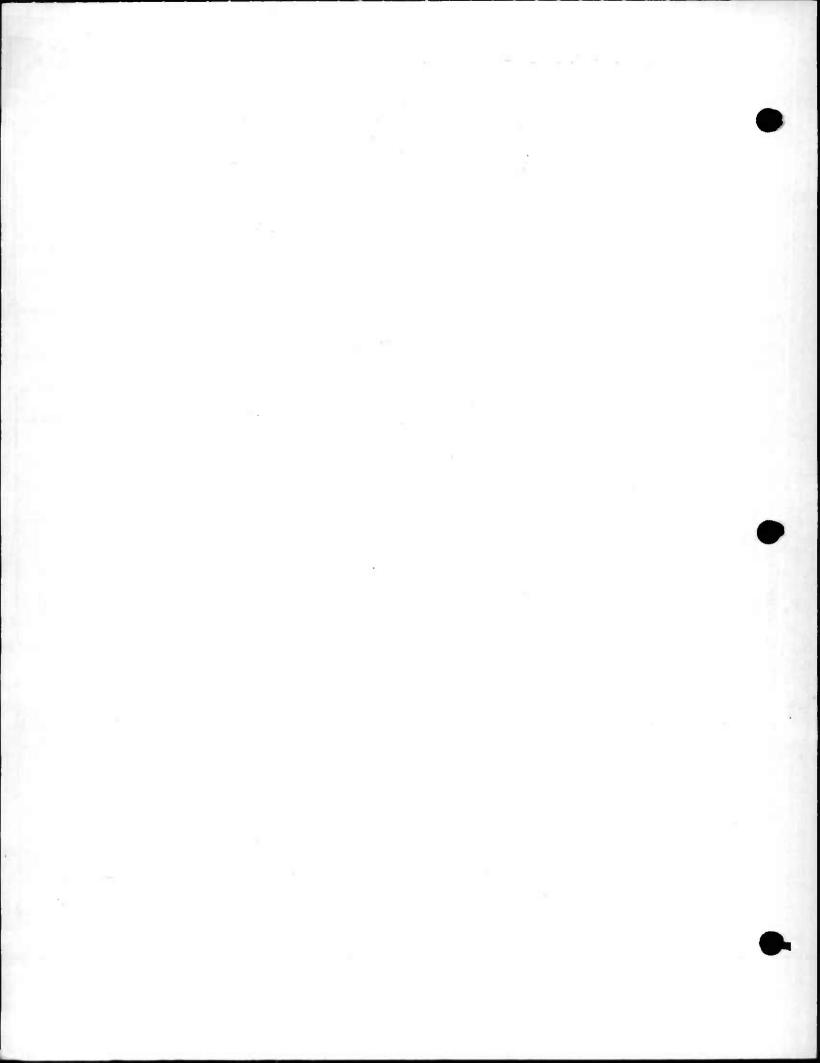
Pages 1, 2, 3 should funeral director, page 5 should be detached for use as the burial-transit permit. 4 hours after death. Page 6 may be retained by the hospital or attending physician. notified at Pe must medical examiner n by the fremoval. completely filled in by cremation, or Injury, or other traumatic event, the TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, crem IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event,

2

31. DATE FILED (Month, Day

95 13423 ITEM: 1. PER F.H. FILM G-723 5/5/95 t.t FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. OECEDENT'S NAME (First, Middle, Last) AKA HOWARD 3. TIME OF DEATH Toward 100 erc SOCIAL SECURITY NUMBER S. SEX 6. AGE (In vrs. last birthday IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 - F DAYS 10 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Street NA RESIDENCE OF DECEDENT 16a. STATE 10b. COUNTY 10c. CITY, TOWH OR LOCATION 10d. INSIDE CITY timore 1 X YES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 505 Wask 21223 Street 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIt yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. RACE Black. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 TES 2 NO В 3 Widowed 4 Divorced Specify: Black COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEOENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY tary/Secondary (0-12) College (1-4 or 5+) Class 8thanuele Welder NA ethlehem 17-FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First. 214 al BE 15 ANFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (St Zip Code) 9 Ho, red a 2121 a_METHOD OF DISPOSITION
Burlel 2 Cremation 3 Removal from State 206. PLACE AND DATE OF DISPOSITION (Name of 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify) em 21. SIGNATURE OF FUNERAL SERVICE LICENSEE NAME AND ADDRESS OF FACILITY UF. H. Was 14. Mid 212/5 inter the diseases, or complications that caused the death. Do not enter the mode shock, or heart future. List only one ceuse on each line. of dying, such as cardiac or respiratory errest, Approximate intervai Between IMMEDIATE CAUSE (Finei **Onset and Death** disease or condition resulting in death) CERTIFICATION Sequentially list conditions, TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OB/AS A CON resulting in death) LAST PART ii. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part !. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 - YES 2 10 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO VI UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) OTHER: 1 YES 2 1 Inpatient 2 ER/Outpatient □ DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED INJURY 1 YES 2 NO BY 2 Accident Investigation 26s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be determined 4 Homicide 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. nation and/or investigation, in my opinion, death occurred at the time. 29d. DATE SIGNEO, (Month, Day, BE

WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)

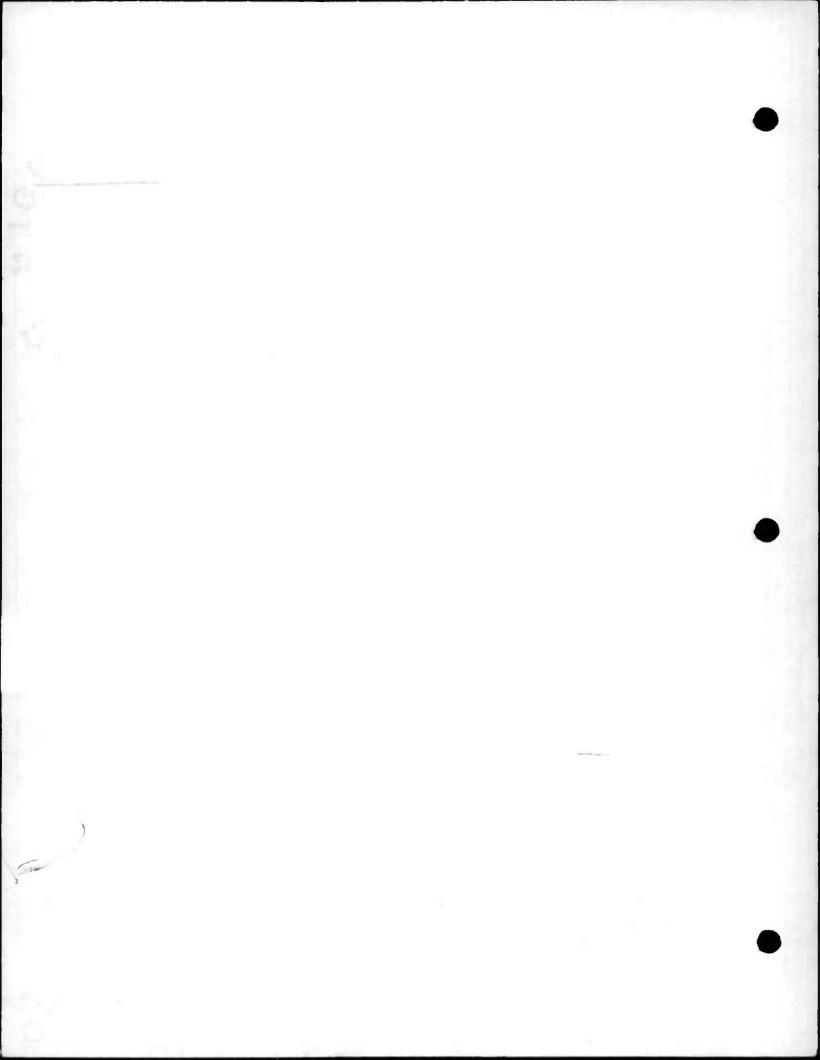


5th ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-724 6/5/95 t.t Item#9.c. G-film 723 per F.H 5/5/95 P.C

95 13424

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THE SHAPE AND TITLE OF CERTIFIER  29b. SIGNATURE AND TITLE OF CERTIFIER  29c. LICENSE NUMBER  29d. DATE SIGNED (Month, Day, Year)  30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  DAVID R. FOWLER M.D. 111 Penn Street, Baltimore, Maryland 21201  31. DATE FILED (Month, Day, Year)  32. REGISTRAR'S SIGNATURE	SIC SR: 4	<b>≅</b> Ω	O ( TOO DO NOT DE	building, atc. (Sp.	IY — Al home, farm, ecify)				City or Town, State)	and Number or 3027 MT	Rural Route	Number, A.V.F.	
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29d. Date signature and title of certifier 29d. Date signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of Death (ITEM 27) (Typo, Print)  DAVID R. FOWLER M.D. 111 Penn Street, Baltimore, Maryland 21201 31. Date Filed (Month, Day, Year) 32. Registrar's Signature	2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	필립	29a. CERTIFIER (Check only 1 CERTIFYING PHYS	ICIAN: To the best of my know	wiedge, death occurr	red at the tim	e, data end place,	end due to the	e cause(a) and mai	ner as atated.			
29d. Date signature and title of certifier 29d. Date signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of Death (ITEM 27) (Typo, Print)  DAVID R. FOWLER M.D. 111 Penn Street, Baltimore, Maryland 21201 31. Date Filed (Month, Day, Year) 32. Registrar's Signature	SPITA ERAI											d manner as stated.	
DAVID R. FOWLER M.D. 111 Penn Street, Baltimore, Maryland 21201  31. Date filed (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	お野	E O											
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OHMH-16 Rav 1/89



3. TIME OF DEATH

10d. INSIDE CITY 1 YES 2 NO

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Md 2121

Approximate interval Between

Onset and Death

8. BIRTNPLACE (State or Fomio

NA

1:04 P.

and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit to burial, cremation, or removal. hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760 signed by the attending physician ar Health and Mental Hygiene prior to 1 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be 170 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician be flied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior is IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traun

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2 Accident

3 Suicide

4 Homicide

permit.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN Raymond Joyner, Jr. 1995 April 28 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 6. AGE (In vrs. last birthday) IF UNDER 24 HRS. 3-84-9763 1 X M 2 - F 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH Medical Center BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10e STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 637 21217 orman 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-it yea, specify Cuban, Mexican, Puerto Rican, stc.)

1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divo 1976 15. DECEDENT'S EDUCATION ecify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5 +) NM grade 16. MOTNER'S NAME (First FORMANT'S NAME (Type/Print) 19h MAII ING ADDRESS /S Joy 20e METNOO UP

1 Burlel 2 Cremation 3 Connection 5 Other (Specify) 20b. PLAG AND DATE OF DISPOSITION FINERAL SERVICE LICENSEE Enter the diseases, Dr complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory street, slock, or heart failure. List only one cause on each line. 23. PART I. IMMEDIATE CAUSE (Finel disesse or condition Sepsis resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Human Immunodeficiency Virus Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If sny, leading to immediate cause. Enter UNDERLYING Pulmonary Hypertension CAUSE (Diseese or Injury that initiated events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a, WAS AN AUTOPSY PERFORMED?

S AN AUTOPSY RFORMED? ES 2 NO	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
)	
OW INJURY OCCU	RED

5/4/95

DID TOBACCO USE CONT	RIBUTE TO CAUSE OF DEATH	YES 🗌 NO 🖾	UNCERTAIN [
WAS CASE REFERRED TO MEDICAL	26. PLACE OF	DEATN (Check only one)	
EXAMINER?	HOSPITAL:	OTHER:	

1 TYES 2 NO Inpatient 2 - ER/Outpatie 3 DOA 4 Nursing Noma 5 Residence 6 Other (Specify 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT

1 YES 2 NO 26e. PLACE OF INJURY — At home, farm, street, factory, office building. etc. (Specify)

261. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER 1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

on, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

P07769

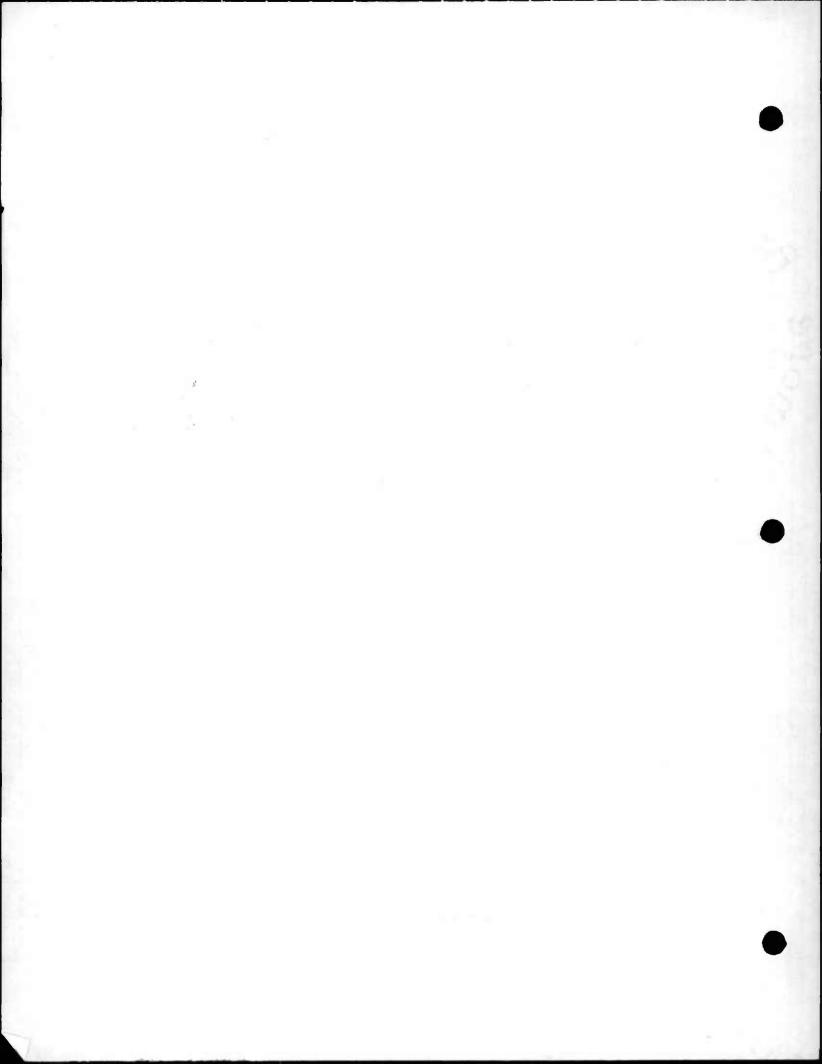
Any COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Michael V. Woodbridge, M.D., 10 North Greene Street, Baltimore, MD. 21201

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BALTIMORE, MARYLAND 21215-0020	urs after death. Page 6 may be retained by the hospital or attending physic	in by the funeral director, page 5 should be detached for use as the burial
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a thours after death. Page 6 may be retained by the hospital or attending physic	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME /First Mickelle Last 2. DATE OF DEATH 3. TIME OF DEATH YEAR Edward Lee Jones 5:15a May 1 1995 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 229-16-5700 1 JM 2 | F 70 Sept.24, 1924 Virginia Se. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 956 Fallridge Way Gambrills Anne Arundel RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Anne Arundel Gambrills 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 956 Fallridge Way 21054 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 √ YES 2 □ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yea, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Married 1 TES 2-NO Specify: BY 3 Widowed 4 Divorced Specify: White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 1st Sargeant U.S. Army 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumeme) Charles Jones notified at BE Virginia 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 956 Fallridge Way, Gambrills, MD 21054 Doris G. Jones å 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must Maryland Veterans Cem 5/5 Crownsville, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LIT 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral HOme, P.A. Ridgely Ave. Annapolis, MD 21401 medicai 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate ahock, or heart feilure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel Onset and Death the state diseese or condition METASTATIC KECTAL CANCER mo resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING other t CAUSE (Disesse or Injury OUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST 6 injury, PART II. Other algorificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a, WAS AN AUTOPSY PERFORMED? MEDICAL WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO any 1 TES 2 NO COMPLETION OF CAUSE OF DEATH? Shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DE PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Hem **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpetient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) -27. MANNER OF DEATH 28a, DATE OF INJURY 28b. TIME DF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 3 Suicide 26s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 26f. LOCATION (Street and Number or Rural Route Number, City or Town, Stale) 28 is 8 Could not be COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(a) and manner as stated. FUNERAL (
within 72 h
TANT: H H TO THE HOSPITA
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IMPORTANT: II MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated, SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) ш 8 2 MAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

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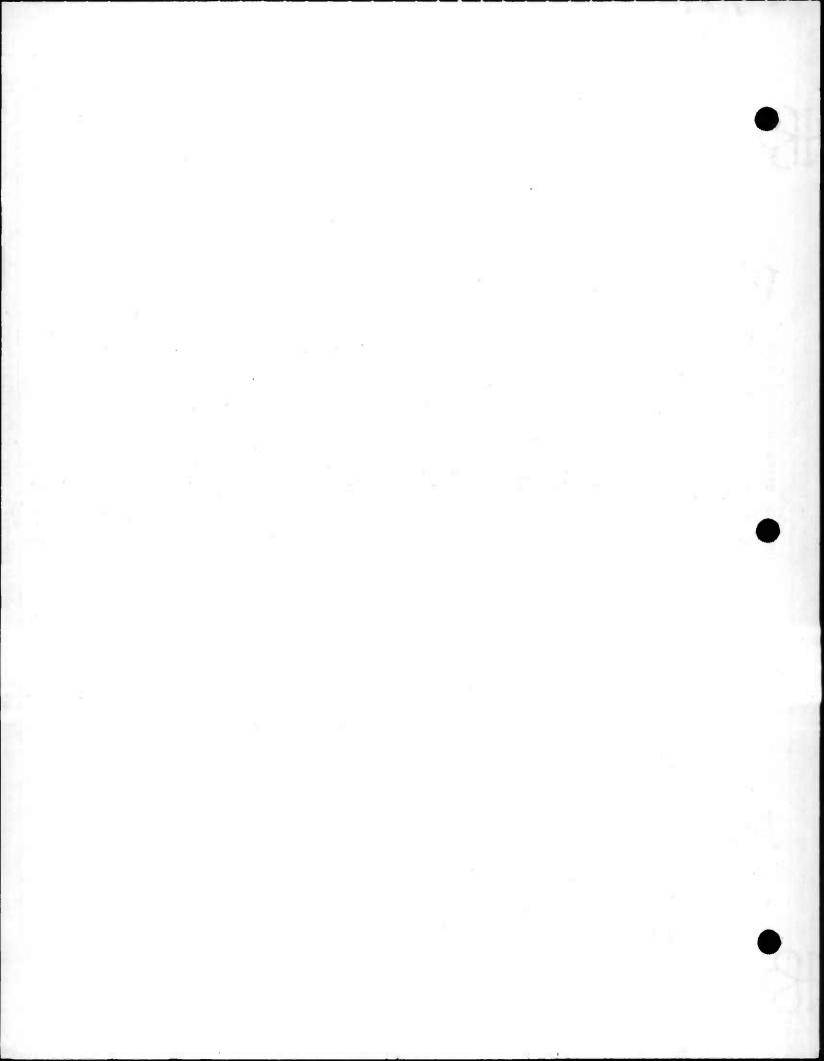
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32. REGISTRAR'S SIGNATURE

Davidson Rardall !

31. DATE FILED (Month, Day, Year)

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30. NAME AND ADDRESS OF PERSON

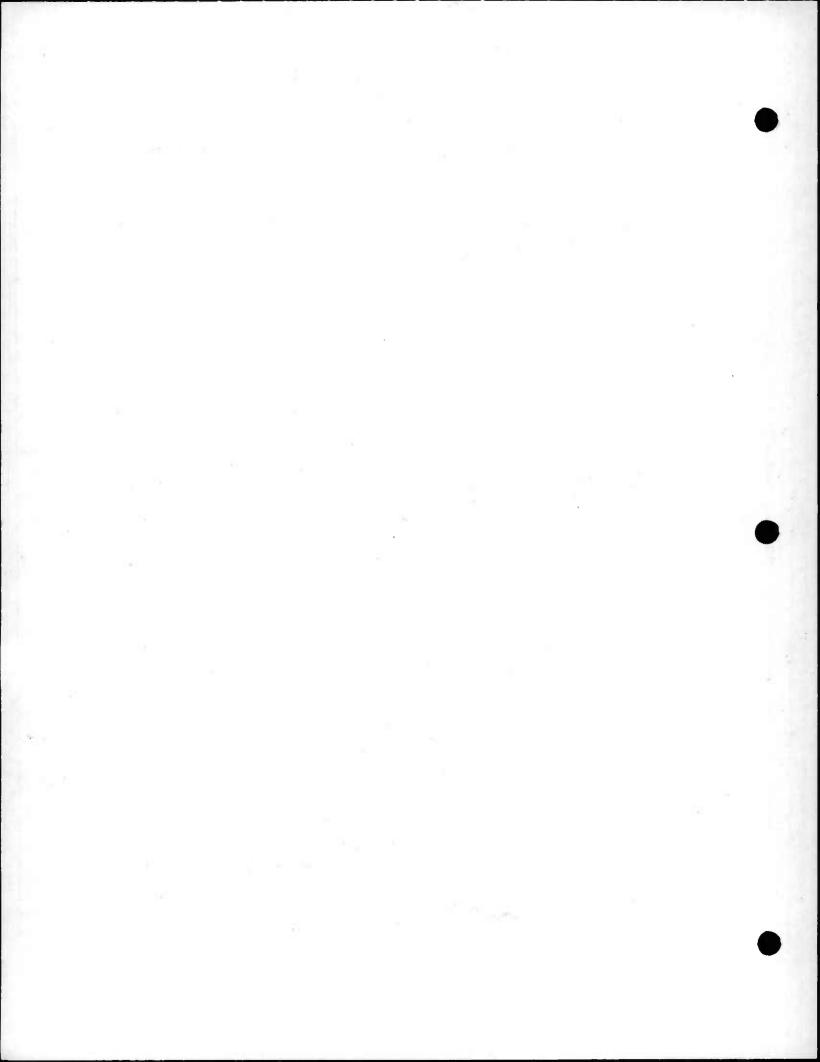
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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 May August Krieg, Sr. Carroll 4:30 A. 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH Sept. 29, 1933 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 213-30-9725 1 X M 2 - F DAYS HOURS Maryland detached for use as the burial-transit permit. Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 8701 Ridgelys Choice Dr. DIRECTOR Baltimore Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Baltimore 1 X YES 2 - NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3713 E. Lombard Street 21224 U.S.A. hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENTYEVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yee, specify Cuben, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cubs IF YES, GIVE WAR OR DATES Spocky: White BY Specify: 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Meat Packer Meat Processing Company once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) James William Krieg funeral director, page 5 should be Anna BE Conley notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Anna M. Bennett (dghtr) 8701 Ridgelys Choice Dr., Baltimore, MD 21236 9 20s. METHOD OF DISPOSITION
1 A Burlat 2 Cremation 3 Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must Oak Lawn Cemetery Baltimore, Maryland 4 Donation 5 Other (Specify). 5/6 medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES 32 NAME AND ADDRESS OF FACILITY Schumuner Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236 filled in by the figon, or removal. 23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximata shock, or heart fellure. List only one cause e on each line. Intervel Batween cremation, or IMMEDIATE CAUSE (Final Onset and Death event, the disesse or condition completely resulting in death) executed with and com other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to If any, laading to immediate cause. Enter UNDERLYING physician 2 death certificate CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST attending signed by the atter Heafth and Mental Injury, PART II. Other algorificant conditions contributing to death but not reculting in the underlying cause given in Pert I. ge de MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? that shows any 1 TYES 2 NO requires 1 | YES 2 | NO peed 6 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h Item HOSPITAL: 1 YES 2 NO DR ATTENDING PHYSICIAN: 1 | Inputient 2 | ER/Outputient 3 | DOA 4 ☐ Nursing Home 5 ☐ Realdence 8 ☐ Other (Specify) 0 the 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED this ( marked, 1 Natural 1 YES 2 NO BY After Investigation 2 Accident DIRECTOR: Aff hours after de item 28 is n 3 Suicide 28s. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 4 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECT DE filed within 72 hours at IMPORTANT: If item 2 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month Day, Year) BE more 3

(TEM 27) (Type, Print)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

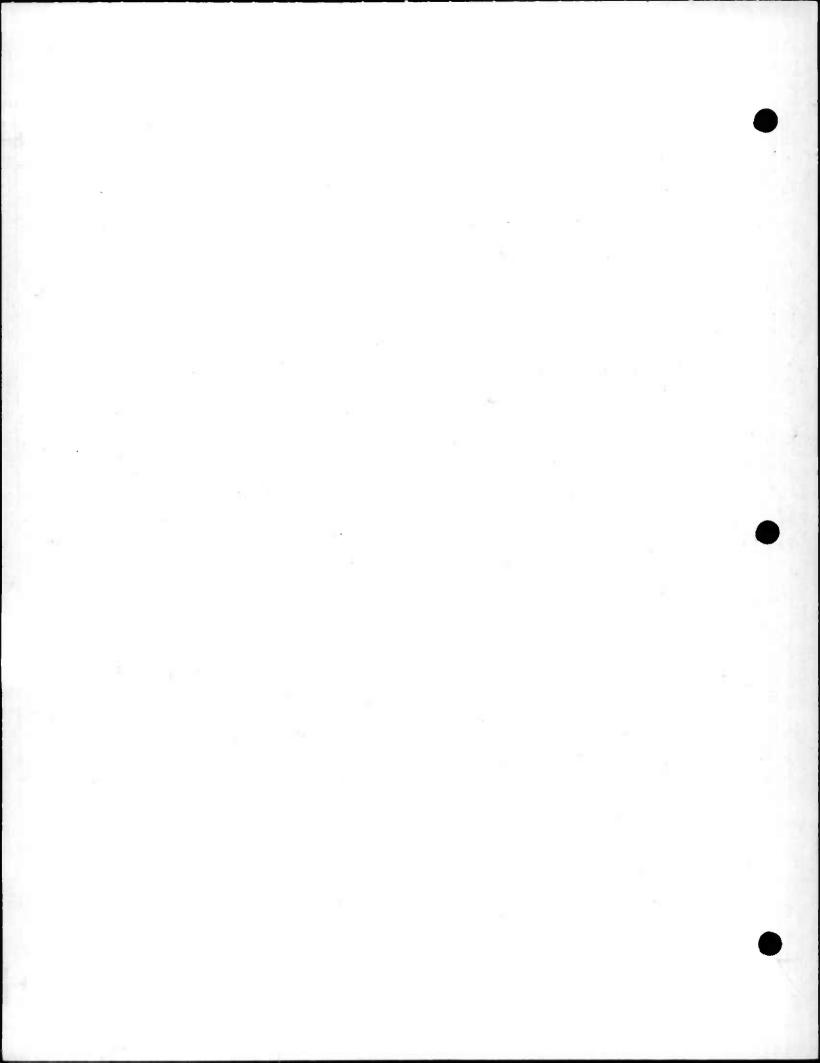
2123



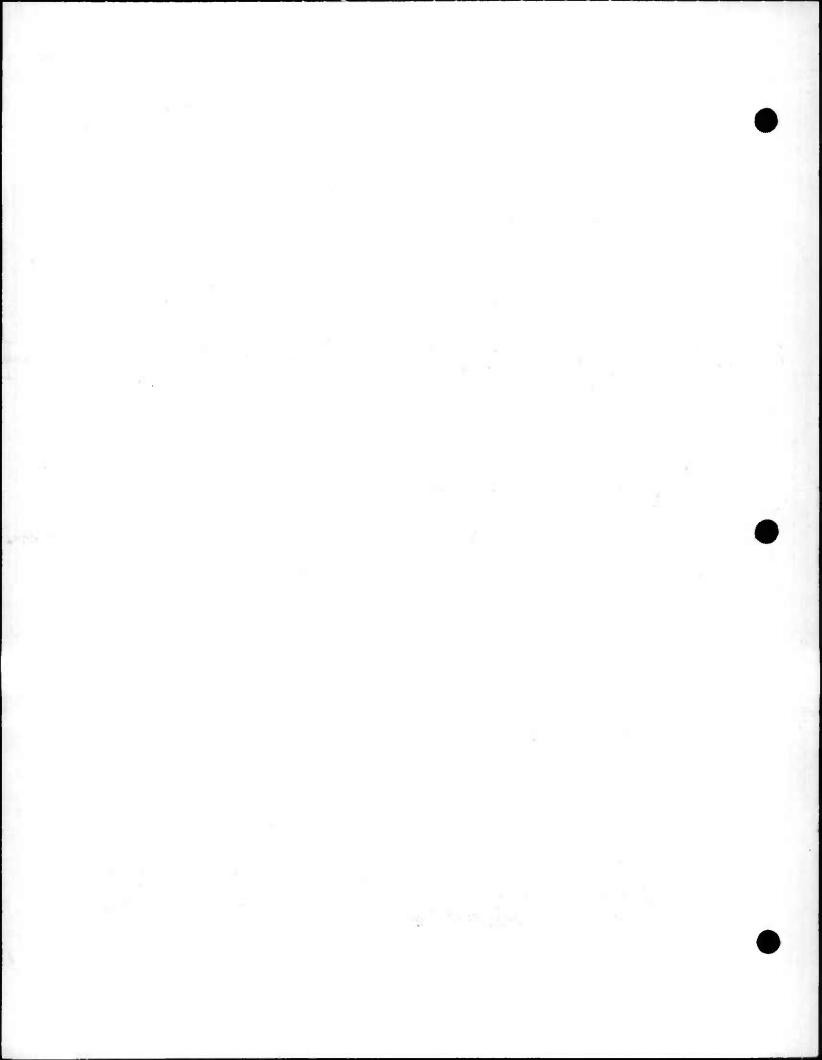
**BALTIMORE, MARYLAND 21215-0020** DIVISION OF VITAL RECORDS, P.O. BOX 68760

HYSICIAN. The law requires that the death certificate be executed with the hours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	. or removal.	medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fi	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	TE OF MARYLAND / [ CEI	DEPARTMEN RTIFICAT	T OF H	EALTH AI	ND MEN	TAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					2. 0	ATE OF DEATH		3. TIME	OF DEATH
	Audrey Jean Kee	enan					Mav_1.	1995	YEAR 1:	30a M
	4. SOCIAL SECURITY NUMBER 5. SEX	ar rose (iii yis: assi s	birthday) IF UNDE	DAYS	IF UNDER 24 I	HRS. 7. D	ATE OF BIRTH Vonth, Day, Year)	6.	BIRTHPLACE (S Country)	tate or Foreign
	130-40-6000 1 1 1 9e. FACILITY NAME (If not institution, give street and	M ² R ^F 64	YRS.			F€	eb.3,19	31 I	Englan	d
Œ		(1997A)			R LOCATION	OF DEATH			Y OF DEATH	_
6	RESIDENCE OF DECEDENT	Road	Jse	vern				Anne	Arund	el
RE	10s. STATE 10b. COUNTY		10c. CITY, TOWN		ION				10d. INS	DE CITY
0	MD Anne Ar	undel	Severi					1 🔀 YES		
FUNERAL DIRECTOR	7941 Tower Court	Road		101. ZIP CODE 21144				10g. CITIZEN OF WHAT COUNTRY?  USA		
S	11. MARITAL STATUS 12. WA	S DECEDENT EVER IN U.S. ARME	ED 13	. WAS DECE	NDENT OF H	HSPANIC OF	IIGIN? (Specify Yes		I. RACE — Ameri Black, White, a	cen Indian.
BY F		RCES? 1 YES 2 NO YES, GIVE WAR OR DATES			cify Cuban, N 2 NO		erto Rican, etc.)			White
	15. DECEDENT'S EDUCATION	16a, DECE	EDENT'S USUAL (	OCCUPATIO	N		16b. KIND OF BU	PINESS INDIAS		
E	(Specify only highest grade complete Elementary/Secondary (0-12) Colleg	(Give	kind of work done to NOT use retired.	during mos	t of working		IOU. KIND OF BU	SINESS/INDUS	) I R I	
COMPLETED	12	Sea	mstres	SS			Cloth	ing		
	17. FATHER'S NAME (First, Middle, Last) Albert E. Scriven				16. MOTHER		rst, Middle, Malden			
BE	190. INFORMANT'S NAME (Type/Print)					Jar		rris		
2	Joseph H. Keenan	79	MAILING ADDRES  141 TOV	ss (Street an Ver (	od Number or I Court	Rural Route	Number, City or Tow Id, Sev	n, State, Zip Co 'ern .	MD 2	1144
	20s. METHOD OF DISPOSITION  1 Buriel 2 Cremetion 3 Removal from	20b. PLACE AN	D DATE OF DISPO	SITION (Nan					y or Town, State	
	4 Donation 6 Other (Specify)		atory or other place	etera				Crow	vnsvil	le,MD
	21. SKINATURE OF FUNERAL BETVICE LICENSEE	2111			ADDRESS (			mc F	2 7	/
_	alex 1 W	ull	1	12 p	idael	v Av	ral Ho	anoli	A. MD	21401
	23. PART I. Enter tha distasse, or complic shock, or heart fellure. List only	ations that caused the deet ly one cause on each line.	h. Do not ente	r the mod	le of dying,	auch aa	cardiec or raapi	ratory arrea		proximate erval Between
	Onset and Death									
	disease or condition								2	O years
z	Sequentially list conditions. Chanic Afrial Fibrillation >5 years									
ATIO	If any, leading to immediate									
FIC	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONSEQUE	MT 11.50	corse	- 76v	rere 1	1, Xral Ko	gurgidu	ton 20	Jyean
CERTIFICATION		Hypertensian							120	) 1000
2	PART II. Other algnificent conditions contri	7.		mel cellulus		a la Dani				
SAL	Hyperlipidemia		uiting in the u	noerlying	ceuse give	n in Part	PERFOR	MED?	AWAILABL	TOPSY FINDINGS E PRIOR TO ION OF CAUSE
					_		1 TYES 2	NO	OF DEATH	?
PHYSICIAN: MED	DID TOBACCO USE CONTRIBUTE	TO CAUSE OF DEATH	YES X	NO 🗆	UNCER	TAIN [	1		1 TES	2 NO
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE (	OF DEATH (Check		1 -			<u>.                                    </u>		
IXSI	1 YES 2 NO 1 In	patient 2 ER/Outpatient 3	DOA 4 INU	rsing Home			Other (Specify)			
	1 Natural 5 Pending	(Month, Day, Year)	28b. TIME OF INJURY	28c. INJU WOR 1 TY	IK?		OEŞCRIBE HOW II	NJURY OCCUR	RED	
) BY	2 Accident Investigation 3 Suicide 6 Could not be	e. PLACE OF INJURY — AI home	, ferm, atreel, fec				LOCATION (Street a	and Number or	Rural Route Numb	er.
COMPLETED	4 Homicide determined	building, etc. (Specify)					City or Town, State)			
2	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To	the beat of my knowledge, death	occurred at the	time, date a	and place, and	d due to the	cause(e) end man	ner ea atated.		
Š	one) 2 MEDICAL EXAMINER: On the	s basis of examination and/or invi	eatigation, in my	opinion, de	ath occured a	it the time,	date and place, en	d due to the c	euse(s) and man	ner sa stated,
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	01 1 10			29c. LICENSE	NUMBER		29d. DATE S	IGNED (Month, De	ly, Ybar)
ဥ	30. NAME AND ADDRESS OF PERSON WHO COMPL	Mobert UTMC	0.0		H 43	3958		5/	3/95	
	600 Kiddel Mu	LETED CAUSE OF OEATH (ITEM 2	T) (Type, Print)	1111	d,	AI	407			
	31. DATE FILED (Month, Day, Year)	REGISTRAR' GIGNATURE	04=	em		~			-	
	MAY UD 1995 AMA	Mandally Land Colonial								- 1



		1 - STATE REGISTRAR	STATE OF I	MARYLAI	ND / DEPAR CERTIF	ITMENT	OF H	DEAT	AND ME	NTAL HYGI REG.			
		1. DECEOENT'S NAME (First, Middle, Lillian K	uer)							DATE OF DEATH	DAY	YEAR 3.	TIME OF OEATN
9		4. SOCIAL SECURITY NUMBER 723-09-2682	5. SEX 1 M 2 X F	6. AGE (In 78	yrs. last birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. 7.	DATE OF BIRTH (Month, Day Year an . 21,	1	. BIRTHPL	ACE (State or Foreign Jersey
2, 3 should	CTOR	Be. FACILITY NAME (If not Institution, give street end number)  Laurel Regional Hospital  Laurel  BestDence of Decement  BestDence of Decement											
t. Pages 1,	DIREC	10a. STATE 10b. CC	~~			y, town o						- 1	d. INSIDE CITY LIMITS?  YES 2 X NO
ı. ınsit permit.	FUNERAL	100. STREET AND NUMBER 82 West Deer	Park Roa	ad Ap	ot. T-]	L		ZIP CODE 2087					T COUNTRY?
215-0020 r attending physician. use as the burial-transit	B	1 Never Married 2 Merried PORCES? 1 YES 2 YNO If yes, specify Cuben, Mexicen, Puerto Rican, etc.)						4. RACE — Black, W Specify: Whi	Americen Indien, /hite, elc.				
Z = Z	APLETED	15. DECEOENT'S (Specify only highest Elementary/Secondary (0-12)		+)	18a. DECEDENT'S (Give kind of v His. Do NOT us BOOKKE	work done se retired.)	during mos		ng		BUSINESS/INDUS		oration
\$ & & &		17. FATHER'S NAME (First, Middle, Les Frederick A	. Dunn					Jul	lia E		rak		
may be retained by page 5 should let the notified		190. INFORMANT'S NAME (Type/Print)  Mr. Kerry D			82 We	est	Dee:	r Pa	or Aurel Aout	oad Ga	Town, Stete, Zip C Lithers	bur	20877 g,MD
e de G		20e METNOD OF DISPOSITION 1 Burlel 2 Cremetion 3  4 Donetion 8 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE		cemete	LACEAND DATE ery, cremetory or o Lafford	ther plece) Me	mor	ial	Pk.	3/29/9	LOCATION - CH	affo	rd, VA
BALTIN after death. Pag by the funeral di moval.		Mountcastle Funeral Home 22191 13318 Occoquan Rd. Woodbridge, VA											
filled in I fon, or re-		23. PART / Enter the diseases, ahock, or heart fell IMMEDIATE CAUSE (Final disease or condition	or complications that ure. List only one can	use on sec	in line.					a cerdiac or re	apiretory arree	ıt,	Approximate interval Batween Onset and Death
executed within 74 I and completely fille o burial, cremation, matic event. the		resulting in death)	DUE TO	OR AS A C	CONSEQUENCE OF	_ <u>C</u> F):	1 A V	(a5)	-				~ 1 + 45h
or to	disease or condition a												
certifica ding ph tygiene		CAUSE (Disease or injury that initieted eventa resulting in death) LAST	DUE TO	(OR AS A C	ONSEQUENCE OF	F):							
that the ded by the th and Me	DICAL	PART II. Other algorificent cond	litions contributing to	deeth but	not reaulting i	n the un	derlying	ceuse g	jiven in Par	PER	AN AUTOPSY FORMEO?	AM CO	PER AUTOPSY FINDINGS ALLABLE PRIOR TO MPLETION OF CAUSE DEATH?
AL KECO the law requires that has been signed is bept, of Health a		DID TOBACCO USE CO						UNC	ERTAIN ]			1 (	YES 2 NO
一年 書 書	SICI/	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL:	ER/Outpeti	ent 3 DOA	OTHER	1:	5 🗆 Re	sidence 6 [	Other (Specify)			
D E state	ву РН	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigat		Day, Ybar)		M		RK7 ES 2 [	NO NO		W INJURY OCCU		
DIRECTOR: After hours after death		3 Suicide 6 Could no 4 Homicide determine	building,	etc. (Specify)						City or Town, St			e Number,
12 K = 12 K	2	2 MEDICAL EXA	HYSICIAN: To the best of MINER: On the beste of e	my knowled	ige, death occurre and/or investigatio	n, in my o	me, data	end place, eth occur	and due to t	the cause(e) end	manner ee atated, , end due to the o	;euse(e) en	d menner ee stated.
TO THE HOSP TO THE FUNE De filed within	TO BE	296. SIGNATURE AND TITLE OF CERT	- CN	1	~,	>		29c. LICE	SO I	4	29d. DATE S	27	onth, Day, Year)
10		30. NAME AND ADDRESS OF PERSON  TS ASSELLA  31. DATE ELLED (Month Day Very	WIND COMPLETED CAU	20 17		Print)	VA	n D	uch	Rd	Low	w.	ПО
10		31. DATE FILED (Month, Day 1997)	July 10 10		OHE								



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4% hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

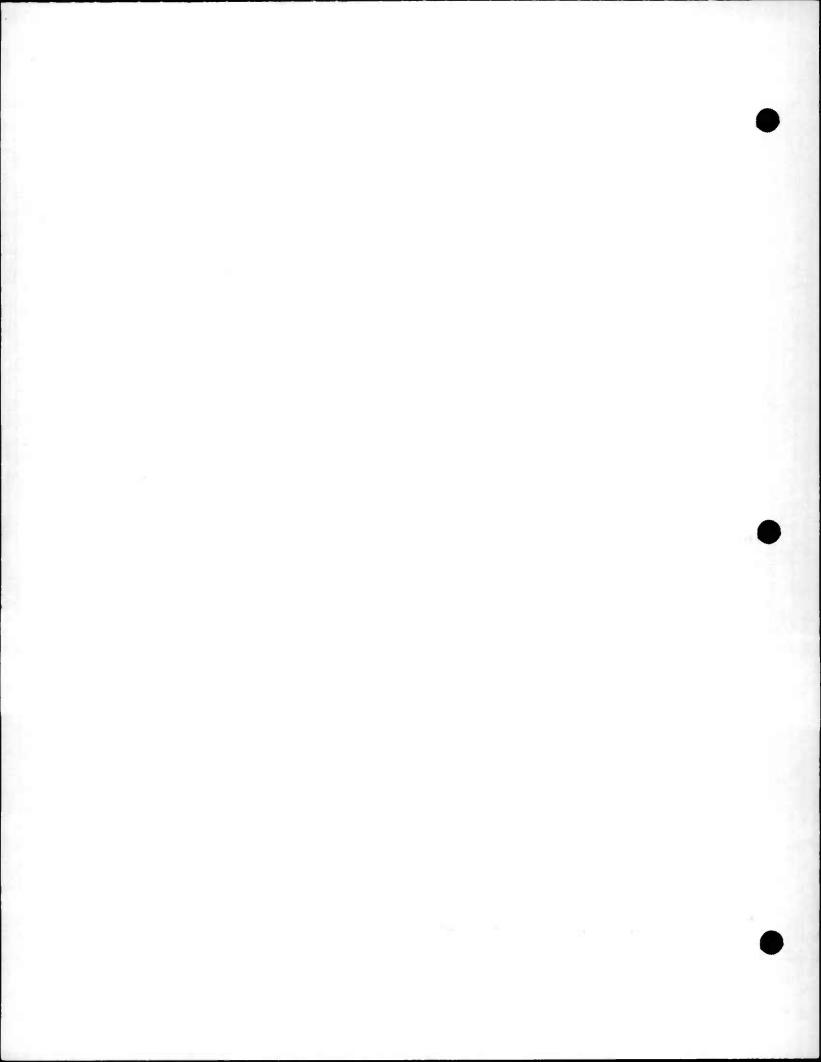
IMPORTANT: If Hem 28 is marked, or Hem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

31. DATE FILEO (Month, Day, Year) MAY 5

1995

32. MEGISTRAN'S SIGNATURED July When the William Navdall

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Lest) DAVID NE	3.200 W W				1995 YEAR	3. TIME OF DEATH 05:37A M			
	220-62-0162	5. SEX 6. AGE (In yrs. 40	YRS. F UNDE	R 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN,	7. DATE OF BIRTH (Month, Day, Year) July 6, 1	8, BIRT	THPLACE (State or Foreign			
TOR	The second second second	9a. FACILITY NAME (If not institution, give street and number)  9b. CITY, TOWN OR LOCATION OF DEATH  THE JOHNS HOPKINS HOSPITAL  BALTIMORE CITY								
DIRECTOR	10e. STATE 10b. COUNTY  Maryland Balt	timore	10c. CITY, TOWN	OR LOCATION Baltimore	2		10d. INSIDE CITY LIMITS? 1 YES 2 X NO			
FUNERAL	100. STREET AND NUMBER 600 Lanoitan Rd. 11. MARITAL STATUS			101. ZIP CODE 21220		U.S.A				
B	1 Never Married 2 Married 3 Widowed 4 Divorced	2. WAS DECEOENT EVER IN U.S. A FORCES? 1 [A YES 2 [ IF YES, GIVE WAR OR DATES 1973-75	ARMED 13.	WAS DECENDENT OF HISPA If yes, specify Cuben, Mexic 1 YES 2 X NO Speci	an, Puerto Rican, atc.)	Bla	CE — American Indian, ck, White, atc. CMY: White			
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12) 12th grade	mpleted) College (1-4 or 5+)	DECEDENT'S USUAL C (Give kind of work done kine. Do NOT use retired.)	during most of working		siness/industry				
BE COM	17. FATHER'S NAME (First, Middle, Last) Richard H. Luers	ssen		18. MOTHER'S N. June	AME (First, Middle, Malden	Surname)				
101	196. INFORMANT'S NAME (Type/Print) Richard H. Luersse	en (father)	13728 Bal	s (Street end Number or Rural dwin Mill Ro	i., Baldwin	, MD 21	1013			
	20e. METHOO OF DISPOSITION  1									
	21. SIGNATURE OF FUNERAL SERVICE LICENT	lastn	5 6 9	chimunek Fur 705 Belair I	neral Homes Rd., Baltim	ore, MD	21236			
	IMMEDIATE CAUSE (Final	it only one cause on each li	na.	r the mode of dying, aud	ch as cardiac or reap	ratory arrest,	Approximata Interval Between Onset and Daath			
	disease or condition resulting in death)  a. Gram Negative Sepsis  Due to (or As a consequence of):									
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING  CALISE CHIEFE TO HOURS  L. Spentaneous Bacterial Peritoritis  4 days  L. Spentaneous Bacterial Peritoritis  4 days  2 years									
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST			20 years						
MEDICAL C	PART II. Other significant conditions c	contributing to death but not	t resulting in the u	ndariying cauaa given in	Part I. 24a. WAS AN PERFOR	MED?	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH?			
IAN: ME	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)									
PHYSICIAN:		IOSPITAL: Inpatient 2 - ER/Outpatient	3 DOA OTHE	R: raing Home 5 - Residence						
BY P	1 Netural 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation (Month, Day, Year)									
ETED	3 Suicide 8 Could not be 4 Homicide determined	26a. PLACE OF INJURY — At I building, etc. (Specify)	home, term, street, fac	tory, office	281. LOCATION (Street a City or Town, State)	ind Number or Rural	Route Number,			
COMPLETED		N: To the bast of my knowledge, of the basis of exemination and/o					(s) end manner as stated.			
TO BE C		racell		29c. LICENSE NU L2903	MBER	29d. DATE SIGNED	O (Month, Day, Year)			
-	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27 (Type, Print)) 600 N. Wolfe Street Johns Hopkins Huspital Ballimore MD 21287-8/06									



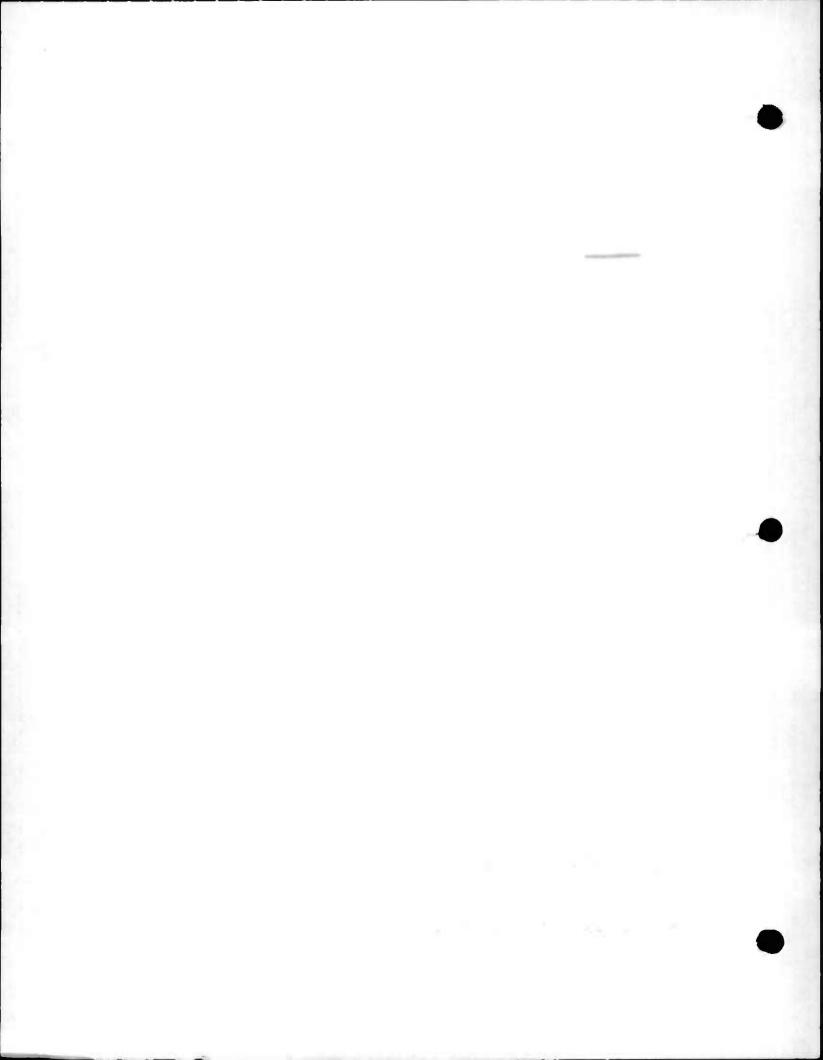
Milsten,

32 REGISTRAR'S SIGNATURE

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First Middle Last 2. DATE OF DEATH 3. TIME OF DEATH Robert C. Mannel May 1, 1995 03:35A. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) 7. DATE OF BIRTN (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign 1 X M 2 | F 215-10-3929 80 Dec. 18, 1914 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR VA Medical Center BALTIMORE N/A RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland N/A Baltimore 1 X YES 2 | NO permit. FUNERAL 100. STREET Parkside 4706 Prkeide Drive 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the bunal-transit 21206 S. A. hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE -- American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 X Merried BY 3 Widowed 4 Divorced WWII White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ntary/Secondary (0-12) College (1-4 or 5+) N/A N/A Steel Worker Bethlehem Steel once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) 7 Louis Mannel Namie Gnau BE notified a 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Bonnie Y. Elwood (Daughter) 19 Winona Ave., Baltimore, Md. 21222 Pe 20g. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, Stata must Oak Lawn Cemetery Donation 6 Other (Specify) 5/4/95 Baltimore, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home Eugene LC 3331 Brehms Lane, Baltimore, Md. n by the fi medical filled in by t 23. PART I. Enter the diseases, of complications that caused the death. Do not enter the mode of dying, such ea cardiac or respiretory arrest, shock, or heart fellure. List only one cause on each line 5 Interval Between Onset and Death IMMEDIATE CAUSE (Final completery filled rial, cremation, c the disease or condition resulting in death) Staph Aureus Sepsis event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): in and comi executed traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate death certificate be I by the attending physician and Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 6 injury, PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. requires that the MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? any Renal Failure signed Health a 1 TYES 2 XNO Shows Chronic Obstructive Pulmonary Disease 1 TES 2 NO t. of t DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN A has be Dept. PHYSICIAN: AMP. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) DR ATTENDING PHYSICIAN: The certificate the State HOSPITAL:
1 Dispetient 2 ER/Outpetient 3 DOA OTHER: 1 TYES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED marked, this with 1 K Natural 5 Pending 1 YES 2 NO BY After 2 Accident 28s. PLACE OF INJURY — At home, farm, street, tectory, offica building, atc. (Specify) 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: A hours after d 60 6 Could not be 4 Nomicide determined ET COMPL 1 🖔 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. TO THE HOSPITAL
TO THE FUNERAL I
be filed within 72 h
IMPORTANT: If I HOSPITAL TREDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) tu 95 0739 9 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

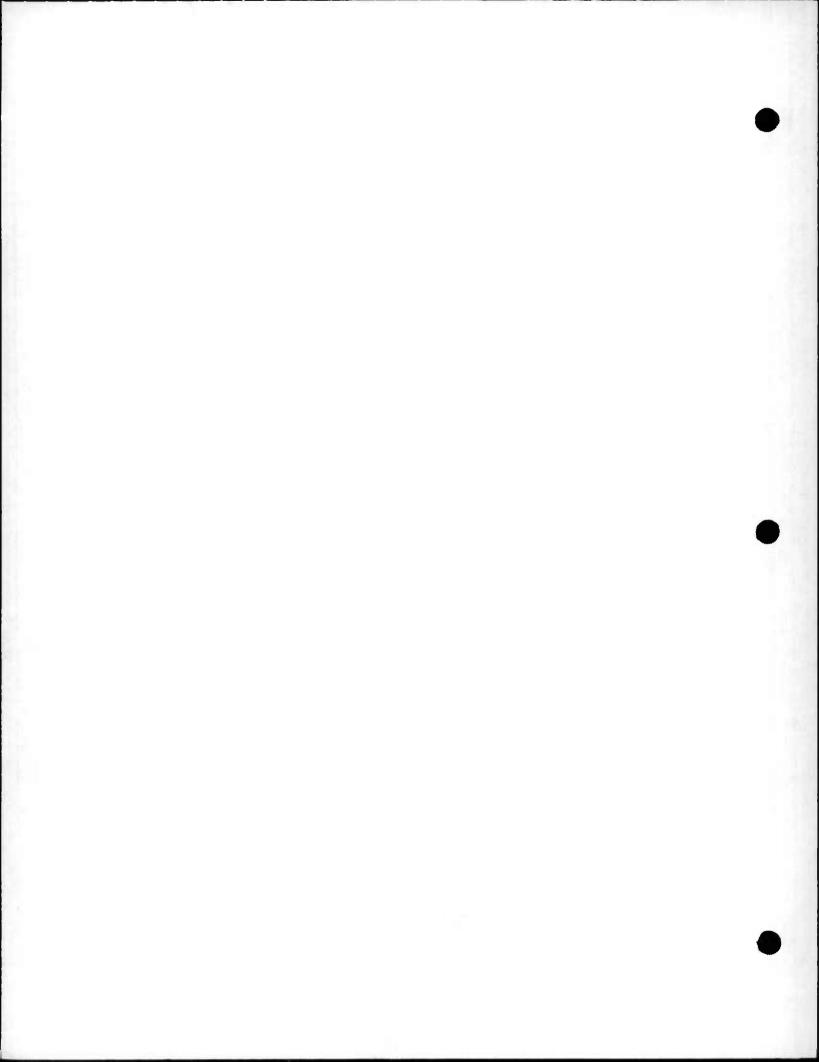
M.D., 10 North Greene Street, Baltimore, MD, 21201, VA Medical Center



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME /First Middle 1 ast) 2. DATE OF DEATH 3. TIME OF DEATH May 3, 1995 YEAR JAMES C. MEYER 9:00 p. 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year)
Sept. 6, 5. SEX 6. AGE (In vrs. last birthday) IF UNDER 24 HRS. 8. BtRTHPLACE (State or Foreign 1 X M 2 | F 216-16-8825 Maryland Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give etreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Lorien Frankford Nursing Home Baltimore N/A RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland N/A Baltimore 1 X YES 2 | NO hours after death. Page 6 may be retained by the hospital or attending physician, edit by the funeral director, page 5 should be detached for use as the burial-transit permit. For removal. FUNERAL 104 STREET AND MIMORE 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3520 Elmora Avenue 21213 U.S.A. 12. WAS DECEDENT, EVER IN U.S. ARMED FORCES? 1 X YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Maxican, Puerto Rican, atc.)

1 □ YES 2 N NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 X Married IF YES, GIVE WAR OR DATES BY Specify: 3 Widowed 4 Divorced White 18a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 10th grade Bottler National Brewing Co. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Caspar Meyer Elizabeth Aires notified at BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 9 Dorothy A. Meyer (Wife) 3520 Elmora Avenue, Baltimore, Md. 21213 9 20e. METHOD OF DISPOSITION
1 Å Burlel 2 Cremellon 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must Dulaney valley Mem. Gardens 5/6 4 Donation 5 Other (Specify) Timonium, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LIGHNSEE 22. NAME AND ADDRESS OF FACILITY Schimunek Funeral Home Eugene and 3331 Brehms Lane, Baltimore, Md. 21213 medical 23. PART I. Enter the diseases, of complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory street, shock, or heart feliule. List only one ceuse on each line. n and completely filled in by to burial, cremation, or remo Approximate interval Batween Onsat and Death IMMEDIATE CAUSE (Fine) the diseese or condition resulting in death) 5 Com DUE TO (OR AS A CONSEQUENCE OF): event. traumatic CERTIFICATION Sequentielly liet conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leeding to immediate uires that the death certificate be e signed by the attending physician Health and Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or injury other QUE TO (OR AS A CONSEQUENCE OF): that initieted events regulting in deeth) LAST 6 injury. PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? shows any 1 YES 2 1 TES A NO t, of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: . OR ATTENDING PHYSICIAN: The law in DIRECTOR: After this certificate has be hours after death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TYES 2 CHO 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 8 Other (Specify) 10 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked. 1 Natural 5 Pending 1 YE6 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, lerm, street, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 COMPLETED 6 Could not be 4 Homicide 28 determined item 29a. CERTIFIER
(Check only one)

2 MEDICAL EXAMINER: On the basis of examination and/or (received to the course) of the basis of examination and/or (received to the course) of the basis of examination and/or (received to the course) of the basis of examination and/or (received to the course) of the basis of examination and/or (received to the course) of the basis of examination and/or (received to the course) of the basis of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the course of the cou TO THE HOSPITAL O TO THE FUNERAL DI be filed within 72 ho IMPORTANT: If ite 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner ee stated. 296. SIGNATURE AND TITLE OF CAME 29c. LICENSE NUMBER 29d. DATE SIGNED (Monthy Day, Year) BE 72067 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5810 Belgin Nd Z1206 eve



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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ELWARD JR. 1ANNION 12:30 p.M MAY 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Mgnth, Day, Year) 8. BIRTHPLACE (State or Foreign 1 X M 2 - F 0 32-1225 NOV 27. 9e. FACILITY NAME (If not institution, give street end no 96, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 3520 54. DIRECTOR E FIREDRE RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? HIMORE 1 K YES 2 NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 3520 AURT 21224 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuben, Mexican, Puerto Rican, stc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 1 Never Married 2 Married FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES BY White 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5 +) ecomotive 12 ENGINEER YCARS ARS 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Midd notified at TANNION BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Stre 2/22 2 3 5 ANNION pe 20a, METHOD OF DISPOSITION

1 Burlel 2 Cremailon 3 Re
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION must 21. SIGNATURE OF TUNERAL SERVICE LICENSEE examiner LINERAL CONKING 5 21224 medical 23. PART I. Enfer the diseases, or fompilications that caused the deeth. Do not enter the mode of dying, such as pardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate interval Between **IMMEDIATE CAUSE (Fine)** Onset and Death the disease or condition Myocasone Infonto resulting in death) Much other traumatic event, DUE TO (OR AS A CONSEQUENCE OF): F-Brillo 0 121 CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING Arteriollente VATaler CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? Apresa PERFORMED? shows any 1 YES 2 NO Pulman Bali 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? Item HOSPITAL: 1 Inpatient 2 ER/Outpatie 4 Nursing Home Sy Residence 6 Other (Specify) 10 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Dey, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Netural 5 Pending 1 YES 2 NO ВҰ 2 Accident Investigation 28e. PLACE OF INJURY — Al home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street end Number or Rural Route Number, City or Town. State) 28 is COMPLETED 4 Homicide N Hem 29e. CERTIFIER 2 MEDICAL EXAMINER: On the 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d, DATE SIGNED (Month, Day, Year)

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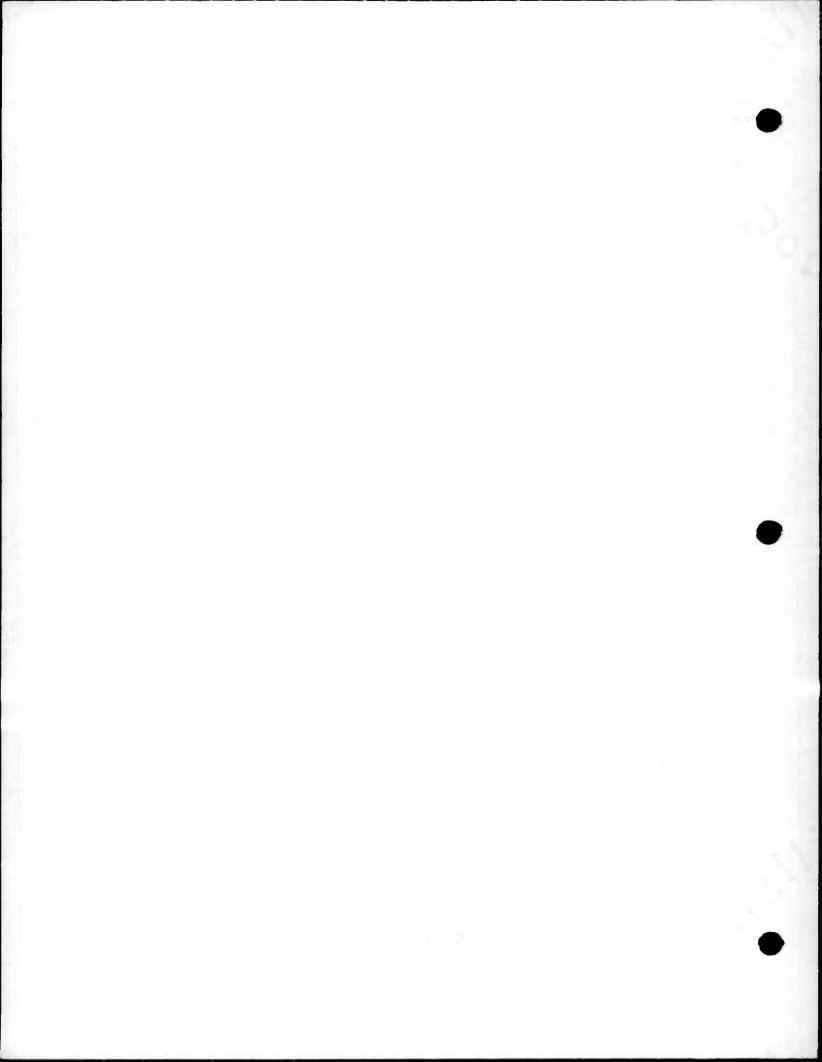
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

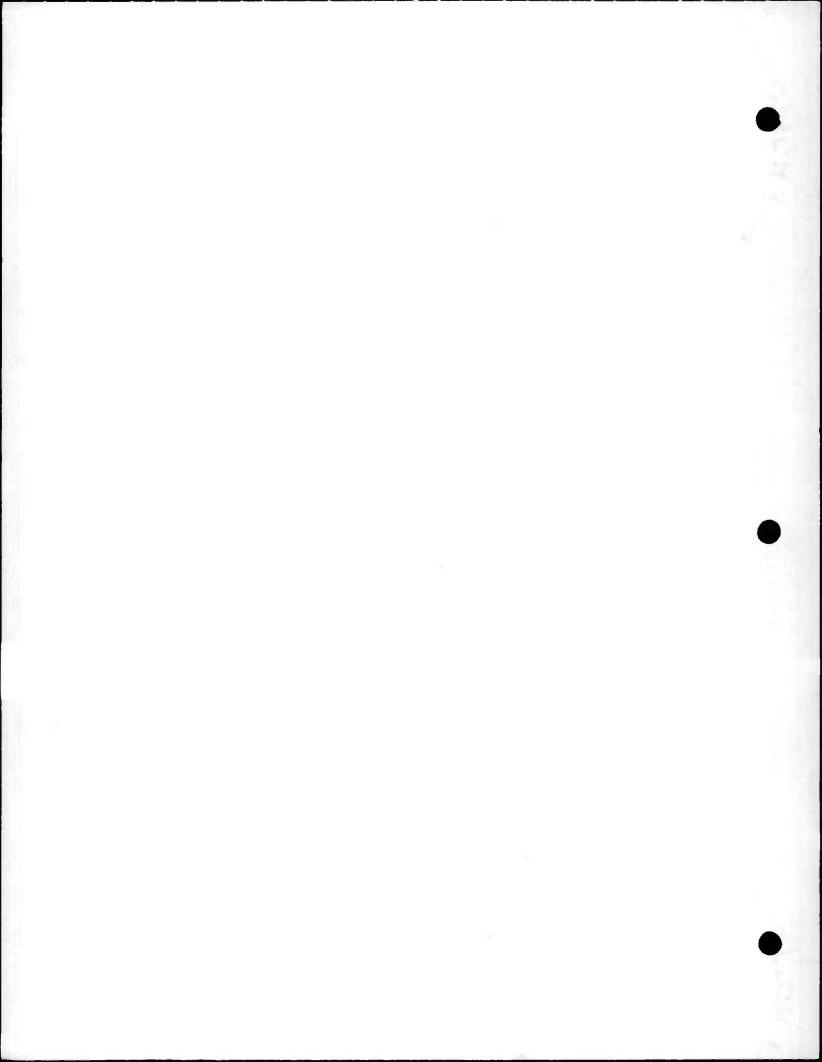


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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3, TIME OF DEATH MONFREDA MAY ietRo 5:45 P. M 8. AGE (In yrs. last birthday) 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 88 1 🔀 M 2 🗌 F MAY Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, the street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH SAMARITAN 2000 DIRECTOR OSPITAL N.A HIMORE RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY NR 1 M Ope permit. 1 YES 2 W NO FUNERAL AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4223 GARLAND AVENUE 21236 funeral director, page 5 should be detached for use as the burial-transit death. Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-It yes, specify Cuban, Maxican, Puarlo Rican, atc.)

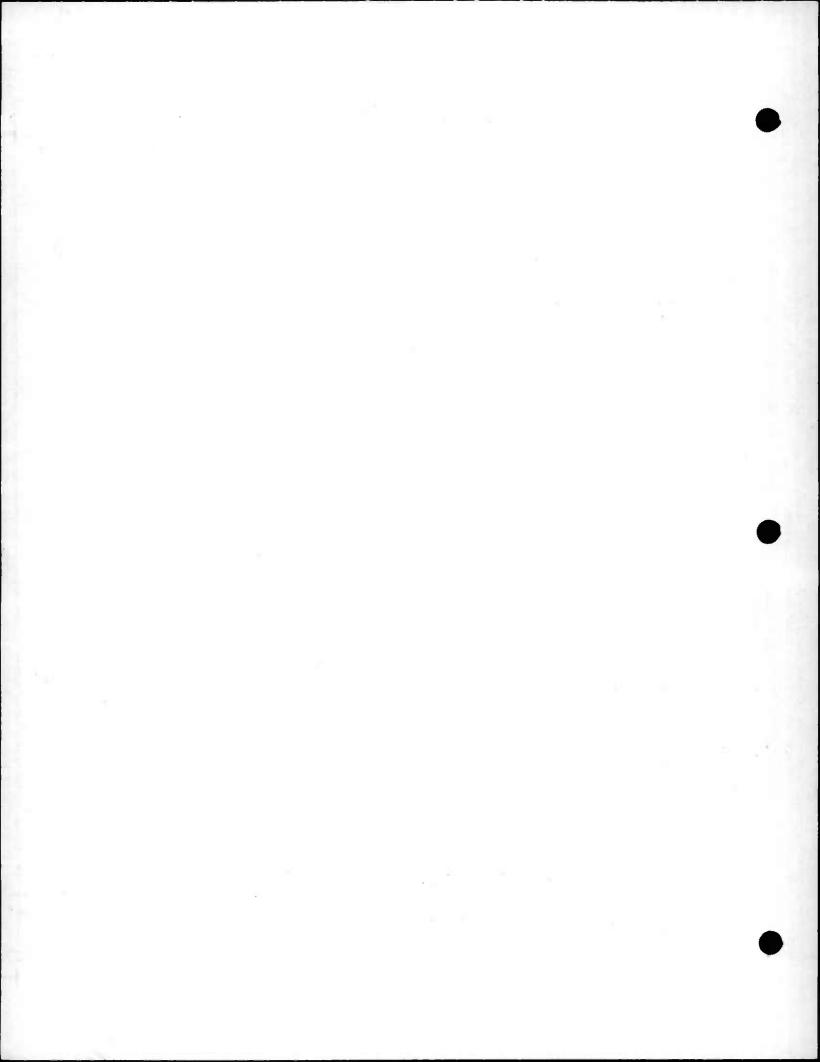
1 TYES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 14. RACE - American Indian, Black, White, etc. 1 Never Married 2 Married ¥ Wkite 3 🔣 Widowed 4 🗌 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY of BAltimore ntary/Secondary (0-12) City College (1-4 or 5+) Dept CONSTRUCTION 746 N.A. OFWAter 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) ONFREDA notified at 1COLA L Aur BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Str 2/236 State, Zip Code 2 AMPANELLA 4223 GARLAND pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must 20c. LOCATION - City of 1 Durial 2 Cremetion 3 Removal from State
4 Donation 5 Doner (Specify) FATOMSHCAT 5-6-95 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF Joseph 263 5. CONKliNG St. the or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cardiec or respiratory arrest, shock, or heart tailure. List only one cause on each line. filled in by Approximata interval Betwe IMMEDIATE CAUSE (Final **Onset and Daath** event, the disease or condition resulting in death) and completely fi burial, cremation UE TO (OR AS A CONSEQUENCE OF): ral traumatic CERTIFICATION Sequentially list conditions, 9 DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING physician the attending physician Mental Hygiene prior CAUSE (Disease or injury injury, or other DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in deeth) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS signed by the AWAILABLE PRIDR TO COMPLETION DF CAUSE PERFORMED? reby shows any 1 TYES 2 TO NO DF DEATH? 1 TES 2 NO t of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \( \Boxed{1}\) NO \( \boxed{N}\) UNCERTAIN \( \Boxed{1}\) PHYSICIAN: has b 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) certificate to the State EXAMINER? HOSPITAL: OTHER: 1 TYES 2 NO Inpatient 2 ER/Outpatient 3 DOA 4 K Nursing Home 5 Residence 6 Other (Specify) 10 27. MANNER OF DEATH 284. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? marked, 28d, DESCRIBE HOW INJURY OCCURED this c 1 🔀 Natural 5 Pending N.A.M N.A. BY 1 YES 2 NO After death 2 Accident 26s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, 00 COMPLETED 6 Could not be DIRECTOR: / 4 Homicide 28 determined N.A Item 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL (
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BE filed within 72 h
IMPORTANT: If It 2 MEDICAL EXAMINER: On the basis of examin ation and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BAItO MR GOOD SAH. Sireesh TRIPURANENI Hospital 5601 32. REGISTRAR'S SIGNATURE 0 5 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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		FOR STATE REGISTRAR	STATE OF MARYLAN	ID / DEPAR CERTIF	RTMENT OF I	HEALTH AND	MENTAL HYGIEN		
		DECEDENT'S NAME (First, Middle, Last)     SOCIAL SECURITY NUMBER	Killian A	· /	lilligar	<b>5</b>		<b>9</b> , 19	3. TIME OF DEATH 3:40 A M
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permit. Pages 1,	DIRECTOR	10e, STATE 10b, COUNTY	NA	10c, CIT	Baltimer			10d. INSIDE CITY LIMITS?  1 YES 2 NO	
n. insit perm	FUNERAL	3902 F. H.Mart	Ave			1. ZIP COOE 2/2/5		10g. CITIZEI	N OF WHAT COUNTRY?
tending physician. as the burial-transit	BY	11. MARITAL STATUS 1 Nover Married 2 Married 3 Widowed 4 Divorced  12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES			13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— It yea, apecify Cuben, Maxican, Puano Rican, stc.)  1  YES 2 NO Specify:  12. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— Black, White, atc. Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: Specify: S				
al or att for use	PLETED	15. DECEDENT'S EDUCA (Specify only highest grade co	TION 18e (mploted) 18e (V A-	(Give kind of life. Do NOT u	S USUAL OCCUPATION Work done during more retired.)	ON ost of working	16b. KIND OF BUS	SINESS/INDUS	TRY
be det	E COMPL	17. FATHER'S NAME (First, Middle, Last)  Me Hand De P	wand		estic	18. MOTHER'S NA	AME (First, Middle, Maiden	Surname)	
retained 5 should notified	TO BE	19a. INFORMANT'S NAME (Type/Print) EVA Duncan	NESCA	196. MAILING	AOORESS (Street of		Acute Number, City or Tow.	n, State, Zip Co	ide)
ay be		20a METHOD OF DISPOSITION 11/C Burial 2 Cremation 3 Remove 4 Donation 6 Other (Specify)		ACE AND DATE y, crematory or	OF DISPOSITION (A)	law	1041	CATION - CITY	or Town, Stata
death. Page funeral dir examiner		21. SIGNATURE OF FUNERAL SERVICE LICEN	March		22. NAME AI	ND ADDRESS OF FA	CILITY DEST	May Ball	6, nd 21215
ed within 24 hours at completely filled in by at, cremation, or rem event, the medic	NC	MMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions.	PANCY TO DUE TO (OR AS A CO) DYS MYE	PEN INSEQUENCE O LO PE	PIA DETIC		h as cardiac or reepi	ratory arrest	Approximata interval Between Onset and Daath 3 most.
death certificate be execut attending physician and central Hygiene prior to buni iry, or other traumatic	ERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST	DUE TO (OR AS A COL						
requires that the een signed by the of Health and M shows any inju	IN: MEDICAL C	PART II. Other algnificent conditione  LEFT LUNG  DIABETES  DID TOBACCO USE CONTRI	MELLOTT	45	BLY (	CANCE	POUL 1 X YES 2	IMEO?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION DF CAUSE DF DEATH?  1 YES 2 NO
SICIAN: The certificate he the State [1, or Item	PHYSICIAN:		28. F HOSPITAL:  Inpatient 2 ER/Outpatier		TH (Check only one)  OTHER: 4  Nursing Hom	e 5 D Residence	8 Other (Specify)		
ING PHYSICIA frer this certificate the the the the the the the the the t	ву РН	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b, TiM	JURY WO	URY AT PRK? YES 2 NO	28d. DEŞCRIBE HOW II	JURY OCCUR	ED
TTEND TOR: A after d	8	3 Suicide 6 Could not be 4 Homicide dstarmined	28s. PLACE OF INJURY — A building, atc. (Specify)	At home, ferm,	street, tactory, office	a	28t. LOCATION (Street a City or Town, State)	nd Number or I	Rural Route Number,
N N N N	COMPLET	one) 2 MEDICAL EXAMINER:	N: To the best of my knowledge On the basis of axamination and						ause(s) and manner as stated.
TO THE HOSPI TO THE FUNER be filed within IMPORTANT:	TO BE	396 SIGNATURE AND TITLE OF CERTIFIER	-u m	0		D24	ABER 9	29d. DATE SI	GNED (Month, Day, Year)
2	1	30. NAME AND ADDRESS OF PERSON WHO ( A - O SEL - W U  31. DATE FILEO (Month, Day, Year)	SUM 5 5	710 )	Print)	et fo	E. BAC	T. Mi	26215
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

Jeath. Page 6 may be retained by the hospital or attending physician. funeral director, page 5 should be detached for use as the burial-transit ours after death. filled in by the ion, or removal. the cremation. signed by the attending physician and completely Health and Mental Hyglene prior to burial, crematic The law requires that the death certificate be executed with r this certificate has been sin with the State Dept. of Hisarked, or Item 23 show DR ATTENDING PHYSICIAN: After death hours after desitem 28 is n TO THE HOSPITAL DR ATT TO THE FUNERAL DIRECTL be filed within 72 hours at IMPORTANT: If Item 2

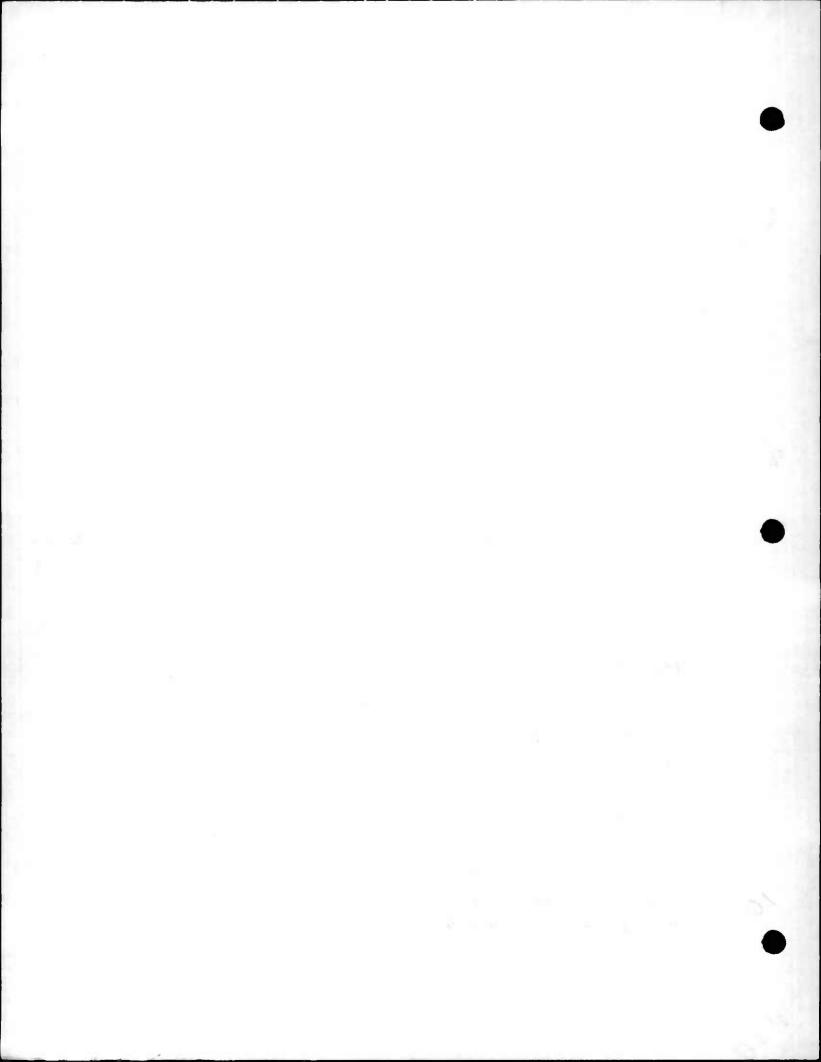
ITEM: 6. PER F.H. FILM G-723 5/5/95 t.t STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Martini 1995 Marcia Ann 26 4 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) S. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS 42 220-50-8450 1 🗌 M 2 💢 F YRS. 1952 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 1722 Aliceanna St. Baltimore N/A DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION N/A Baltimore Maryland 10s. STREET AND NUMBER FUNERAL 10f. ZIP CODE 1722 Aliceanna St. 21231 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—if yes, specify Cuban, Maxicen, Puerto Ricen, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married В 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION ETED 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe ntary/Secondary (0-12) College (1-4 or 5+) COMPL 12

10d, INSIDE CITY 1 X YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? . A 14. RACE — American Indian, Black, White, alc. Specify: White Computer Operator Self-employed years 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Betty Daniel F. Martini Fidler 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22202 VA 1900 S.Eads St. Apt. 704 Arlington, Daniel F. Martini 200. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 1 Buriel 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) Greenwald Cemetery 4/27 Baltimore, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Lilly & Zeiler, Inc. Funeral Home atherine 1901 Eastern Ave. Baltimore, MD2123 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on such line. Approximats Interval Batwesn IMMEDIATE CAUSE (Final **Onset and Death** Myounded Infacto disease or condition resulting in desth) DUE TO (OR AS A CONSEQUENCE OF) DDm Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: 1 XES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO Investigation 2 Accident 3 Sulcide 28e. PLACE OF INJURY — Al home, ferm, atreet, fectory, office building, etc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide datermined 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the firme, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day! Year) Wms D3344 5 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1324 Kenneth Williams, M.D. Patterson Park Med. Center, 2801 F6ste July 32 Hardrey Carolist 31. DATE FILED (MONIS DE 1995

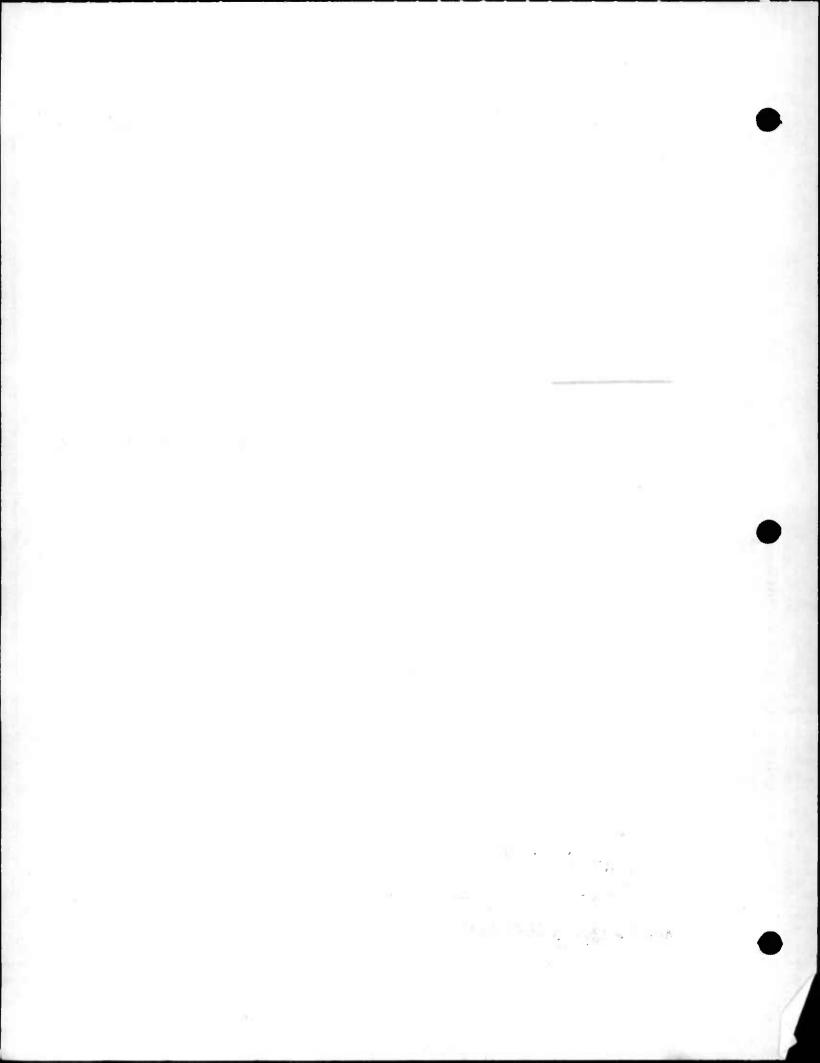
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with
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	1 - STATE REGISTRAR	STATE OF MARYL	AND /	DEPARTM	ENT OF H	IEALTH AND	MENT	AL HYGIEN REG. NO.	E		
Correction of the Control	1. DECEDENT'S NAME (First, Middle, Las	" MICHAL					2. DAT	E OF DEATH	19	7EAR 3.	TIME OF DEATH
-	4. SOCIAL SECURITY NUMBER 219-20-6477	1 🕅 M 2 🗆 F	(In yrs. las	YRS.	UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DAT	e of BIRTH	,1928	Couptry) Mar	ACE (State or Foreign yland
СТОВ	90. FACILITY NAME (# not institution, give Church Home RESIDENCE OF DECEDENT	street end number)		1 -		ore City			9c. COUNT	of DEAT	H
DIREC	100. STATE 100. COUN	тү			imore						M. INSIDE CITY LIMITS?
FUNERAL	701 South Montfo	rd Avenue			101	21224			U.S		T COUNTRY?
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES	2)(2)(1)	MED NO	If yes, sp	ENDENT OF HISPA ecity Cuban, Mexico 2X NO Specifi	in, Puerto	IN? (Specify Yee Rican, atc.)	or No — 14	Black, W Specify:	American Indian, rhite, atc. White
LETED	15. DECEDENT'S E( (Specify only highest gra		(Gi	CEDENT'S USU ive kind of work Do NOT use re	done during mo tired.)		10	Sb. KIND OF BUS		TRY	
COMPL	8 17. FATHER'S NAME (First, Middle, Last) Benjamin Michal	gki	1	nspect	or	18. MOTHER'S NA Joseph	ME (First	Middle, Meiden	ral Mo	tors	
TO BE	19a. INFORMANT'S NAME (Type/Print) Linda Michalski					ood Aven	Floute Nui	mber, City or Town			1224
	Linda Michalski  727 S. Lakewood Avenue  Baltimore, MD 21224  206. METHOD OF DISPOSITION  1 X Burlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. PLACE AND DATE OF DISPOSITION (Name of Specify)  Stanislaus Cemetery 5/4/95  Baltimore, MD										
	21. SIGNATURE OF FUNERAL SERVICE I	icensee th A. Sel	ins	ki	22. NAME AN Lilly 1901	& Zeile Eastern	r, I Aver	nc. Fu	neral	Home	1231
	23. PART I. Enter the diseases, Dishock, or heart fellure immEDIATE CAUSE (Final disease or condition resulting in death)	a. CADIO	ech line				h aa ce	rdlec or respli	ratory arrea	2	Approximate Interval Batween Onset and Death
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  b. MYDCANDIAL INFANCTION  2 DAYS  C. UND NAMY MYDMY DISEASE  YEARS  d. AMDMINSCLEMONE CAMDINVASCHUM DISEASE YEARS										
MEDICAL CE	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.						24e. WAS AN PERFORE	AUTOPSY MED?	24b. WEI AVA COI	RE AUTOPSY FINDINGS ALLABLE PRIOR TO MPLETION OF CAUSE DEATH?	
ż	DID TOBACCO USE CON	TRIBUTE TO CAUSE C				UNCERTAII	N			1 [	YES 2 NO
YSICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL:			HER:	e 5 🗆 Reeldence	6 🗆 Oth	er (Specily)			
ву рну	27. MANNER OF DEATH  1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY	WO	URY AT RK? 'ES 2 NO	28d. DE	SCRIBE HOW IN	JURY OCCUR	ED	
TED	3 Suicide 6 Could not be determined  28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify)  28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						Number,				
COMPLI	2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) and menne							d menner as stated.			
TO BE (	29b. SIGNATURE AND TITLE OF CERTIF	1 WKMD				DISI			≥ M	GNED (MO	inth, Day, Year)
		SCUTTMD	100	1 27) (Type, Print) N, B)	LOADU	IN BA	SIM	IUNE, A	10 2	.12	31
	MAY U 5 1995	HEGISTRAN SIGN	TYPE								



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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I	tem#17.G-film 7	23 per F.H 5	/5/95	P.C				95	13430
	1 - FOR STATE REGISTRAR	STATE OF MARYLANI	D / DEPAR	TMENT OF I	HEALTH AND	MENTAL	HYGIEN	E	
	1. DECEOENT'S NAME (First, Middle, Last)  CHERYL No	Esmith				2. DATE OF	DA	30 19	year 1845 M
	4. SOCIAL SECURITY NUMBER	MONTHS DAVE IN					F BIRTH Day, Year)		B. BIRTHPLACE (State or Foreign Country)
	BR. FACILITY NAME (If not institution, give s	1□M2 XF 36	YRS.	YRS. 4-25-59 N∈				New York	
Œ		,			OR LOCATION OF			9c. COUNT	TY OF PEATH
[ 음	St. Agnes Host		Baltimore City 7 /					CIA	
DIRECTOR	10e. STATE 10b. COUNTY	. 10	10c. CIT	Y, TOWN OR LOCA	TION				10d. INSIDE CITY LIMITS?
	Maryland 100. STREET AND NUMBER	A I H		Baltimo					1 X YES 2 NO
FUNERAL		and all Did		10	I. ZIP CODE				EN OF WHAT COUNTRY?
NS I	3606 Old Frede	12. WAS DECEDENT EVER IN U.S.	ARMEO	13. WAS 0E0	21229 CENGENT OF HISP	ANIC ORIGIN?	(Specify Yea	Ame 1	
1	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES 2'	E NO	If yes, sp	Decify Cuben, Mexi	can, Puerto Ric	en, etc.)		4. RACE — American Indian, Black, Whita, atc. Specify:
D BY									Black
TED	15. DECEDENT'S EDUC (Specify only highest grade	completed)	(Give kind of a life. Do NOT us	USUAL OCCUPATE work done during mo	ON ost of working	16b. K	IND OF BUS	INESS/INDU	STRY
1 2	Elementary/Secondary (0-12)	College (1-4 or 5 +)		g assis	tant	N,	IPS (A	ia F	tome
COMPLET	17. FATHER'S NAME (First, Middle, Last)		TESTIL	4 02212	18. MOTHER'S N				12/12
BE C	Peter Lefever	Joseph Le	fever		Dorot	hv Sa	unde	rs	
0	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street					Code)
-	Eddie Nesmith					k Rd.			Md. 21229
	20e. METHOD OF DISPOSITION  1 Surial 2 Cremation 3 Remote Control Surial Control Surial Control Surial Control Surial Control Surial Control Control Surial Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Control Co	oval from State cemetery,	, cremetory or o	OF DISPOSITION (Na ther place)	ame of	5/-/	20c. LOC	ATION — CI	ty or Town, Stata
	21. SIGNATURE OF FUNERAL SERVICE LIC		King I	22. NAME A	ND ADDRESS OF I	ACILITY	KAN	64115	freed, MA
	* Werrick (	2. Janu		4611	ick C.	Heigh	ts A	ve.	
	23. PART i. Enter the diseases, or cahock, or heart failure.  iMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one ceuse on each	psis		ode of dying, au	ich aa cardle	c or reaple	atory arre	Approximate interval Between Onset and Death
End stage disease, demenine, 1 yes 2 NO OFF									
					24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1  YES 2 NO				
Z									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:					
H-S	1 YES 20 NO 27. MANNER OF DEATH	16 Inpatient 2 ☐ ER/Outpatient 28a. DATE OF INJURY	28b. TIM		ne 5 🗆 Residence		Specify)	HIM OCCU	050
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TED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined determined					Rural Route Number,			
COMPLET	29a. CERTIFIER (Check only one)  29 medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner se stated.  20 medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner se stated.								
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER Scennin Tov	your M.D.			29c. LICENSE NI	JMBER 062		29d. DATE 5	signed (Month, Day, Year) Till -30 - 95
F	Sound Jov 30. NAME AND ADDRESS OF PERSON WHO SAMIH JARJOUR	St. Agnes	HOSP	Tal 6	ton Ave	= B1	ALTIN	loice	MD 21229
	31. DATE FILED (Month, Day, Year) MAY 0 5 1995	32 REGISTRAR'S SIGNATUR	E						



FilmG, 723, item #1, 5/5/95, cyw, per.f.h. FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 8.30 HENRY MAY 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH S. SEX 6. AGE (In yrs. last birthday) a. BIRTHPLACE (State IF UNDER 24 HRS. Oct. 4, 1929 216-24-8937 1 M 2 | F YRS. Maryland 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Good Samaritan Hospital Pages 1, 2, 3 Baltimore RESIDENCE OF DECEDENT 10a. STATE 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Baltimore Baltimore 1 YES 2 X NO funeral director, page 5 should be detached for use as the burial-transit permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? 3300 Upton Road 21234 U.S.A. hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-BALTIMORE, MARYLAND 21215-0020 RACE — American Indian, Black, White, etc. 1 Never Married 2 Nerried If yes, specify Cuben, Mexicen, Puerto Ricen, etc.)

1 YES 2 NO Specify: BY Specify: Specify: White 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY entary/Secondary (0-12) College (1-4 or 5+) 10th grade Production Supervisor Ice Cream Company 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) notified at John R. Petza Caroline Vogel BE 19e. INFORMANT'S NAME (Type/Print) end Number or Rural Route Number, City or Town, State, Zip Code) 2 3300 Upton Road, Baltimore. MD Rosemary Petza (wife) pe 20e METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State must Sacred Heart of Jesus Cem. 5/5 ☐ Donation 5 ☐ Other (Specify) Baltimore. Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Schimuner Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236 the medical 23. PART / Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory erreat, attending physician and completely filled in by intal Hygiene prior to burial, cremation, or remo Approximate shock, or heart failure. List only one ceuse on each line interval Betwe **IMMEDIATE CAUSE (Fine)** Onset and Death event, the disesse or condition resulting in death) CARDIOMYOPATHY requires that the death certificate be executed within RONAR traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury other DUE TO JOR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 signed by the atte Health and Mental PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY 1 TYES 2 NO OF DEATH? 1 YES 2 NO ō DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ PHYSICIAN: s certificate has be th the State Dept. OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: t TYES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 6 27. MANNER OF DEATH 28e. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? After this ce leath with ti marked, 28d. OESCRIBE HOW INJURY OCCURED 1 Netural 2 Accident 5 Pending Investigation 1 YES 2 NO BY After death 28e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 3 Suicide 00 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) DIRECTOR: # COMPLETED 8 Could not be 4 Homicide 28 TO THE HOSPITAL O
TO THE FUNERAL DI
be filed within 72 ho
IMPORTANT: If ite 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and plecs, end due to the ceuse(e) and manner es stated. 2 MEDICAL EXAMINER: On the basis in my opinion, death occured at the time, date and place, end due to the ceuse(e) end manner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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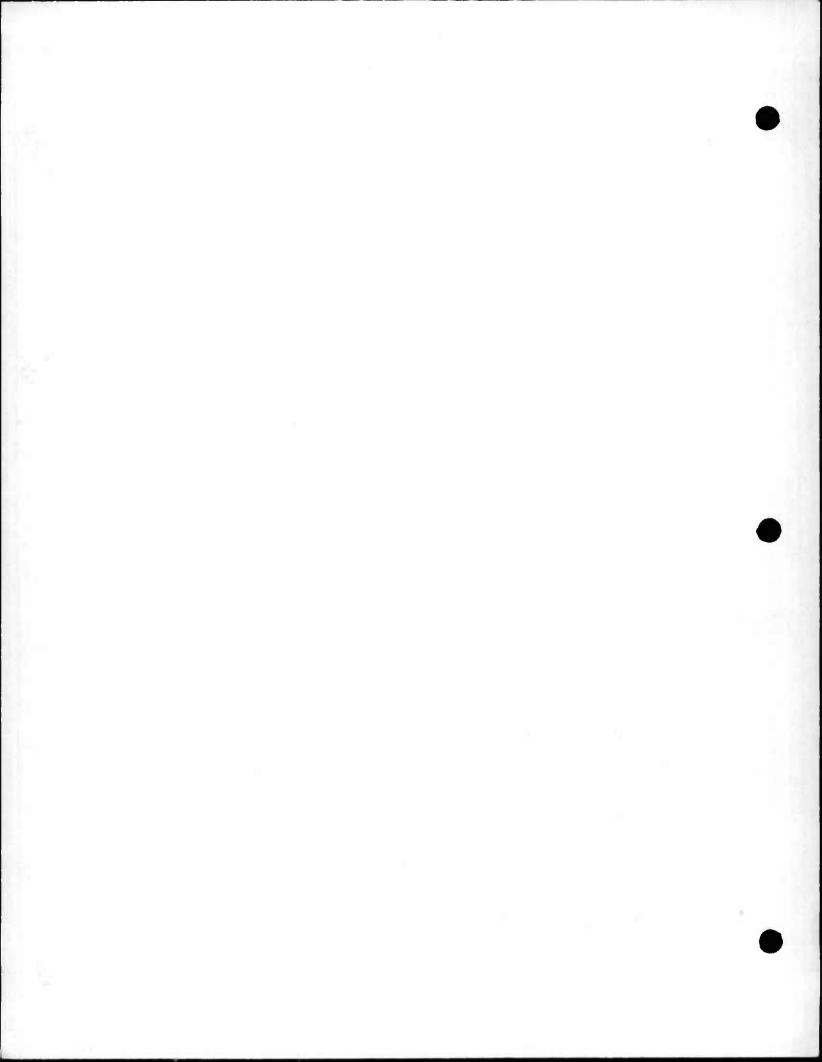
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BALTIMORE, MARYLAND 21215-0020	urs after death. Page 6 may be retained by the hospital or attending physician.	IERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.	edical examiner must be notified at once
DIVISION OF VITAL RECORDS, P.O. BOX 68760	SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	IERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal,	T: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once

Items#1.10.e.G-film 723 per F.H 5/5/95 P.C 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH POTOCKI 5:45 am May 3 1995 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year, OCT - 3) IF UNDER 1 YEAR IF UNDER 24 HRS 218-22-9425 1 XM 2 - F DAYS 928 9a. FACILITY NAME (If not institution, give street 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Saint Joseph Medical Center DIRECTOR **Baltimore** Towson, Maryland RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE 1 YES 2 NO FUNERAL NUMBER 10g. CITIZEN OF WHAT COUNTRY? U. S.A. DOOD 21224 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC DRIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black. White, atc. 1 Never Married 3 Married 1 TYES 2 ND Specify: BY 3 Widowed 4 Divorced WHITE ETED 15. DECEDENT'S EDUCATION pecify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5 +) COMPL LITHO GRADHEL 17. FATHER'S NAME (First, Middle, Last) POTOCKI BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and No 0 817 MD. 21224 BALTO. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION /Name of 1 Suriat 2 Cremation 3 4 Donation 5 Other (Specify) DATE Buriat 2 Cremation 3 Removal from State 21. SIGNATURE OF PRINERAL SERVICE LICENSEE 4UDSON ST 23. PART I. Enter the diseases, or complications that ceused the deeth to not enter the mode of dying, such as cardiac or respiratory errest. ahock, or heert fallure List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition_ **PULMONARY EDEMA** 2 DAYS resulting in death) DUE TO (DR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (DR AS A CONSEDUENCE DF): if any, leeding to immediate cause. Enter UNDERLYING **CAUSE** (Disease or Injury DUE TO (OR AS A CONSEDUENCE OF): that initiated events resulting in deeth) LAST PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? CHRONIC ATRIAL FIBRILLATION 1 YES 2 NO MYOCARDIAL INFARCTION 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATH (Check only one) NOSPITAL: 1 TES 2 NO 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY Investigation Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) S Could not be determined COMPLET 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the besis of exar mination and/or investigation, in my opinion, death occured at the time, data and placa, and due to the cause(a) end manner as stated. TO THE HOSF TO THE FUNE De filed within 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) rogindur D 41410 05-03-95 2

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

31. DATE FILED (Month, Day, Year)

JOGINDER P. MEHTA, MD ST. JOSEPH MEDICAL CENTER TOWSON, MD 21204



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the hospital or attending physician. edetached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

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STATE	0F	MARYLAND / DEPARTMENT	OF	HEALTH	AND	MENTAL	HYGIENE
		CERTIFICATE	0	F DEAT	H		REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA		TMENT OF H		MENTAL HYGIEN	E				
	1. DECEDENT'S NAME (First, Middle, Last)	22121				2. DATE OF GEATH	w wear	3. TIME OF DEATH			
	MATTHEW JOSEPH RU					April 29,	1995 YEAR	1:30 a. m			
		SEX 6. AGE (III	n yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Attack Co. Mark					
~	9e. FACILITY NAME (If not institution, give street	•			R LOCATION OF DE		9c. COUNTY OF	DEATH			
DIRECTOR	Hopkins Bayview Medical Center Baltimore N/A										
H 0	10e, STATE 10b. COUNTY		10c. CITY	, TOWN OR LOCAT	ION			10d. INSIDE CITY			
	Maryland N/A		Ва	ltimore				LIMITS?			
RAL	10e. STREET AND NUMBER			200	ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?			
FUNERAL	3715 BONVIEW AVENUE 21213 U.S.A.  11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yee or No.   14. RACE - American In										
	1 🔀 Never Married 2 🔲 Merried	FORCES? 1 X YES	2 NO		city Cuben, Mexican	, Puerto Rican, etc.)	Blec	E — Americen Indien, ck, White, etc.			
BY	3 Wildowed 4 Divorced 1	2/1/78 to 6	71/83	1 1 123	2 (X) NO Specify:		Spec	White			
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PE		College (1-4 or 5+) ULAUS	General			City	Baltimo	340			
OM	17. FATHER'S NAME (First, Middle, Last)	90000	veneuc	WOTHER	18. MOTHER'S NAM	ME (First, Middle, Meiden		ne			
BE C	Matthew J. Rudolph	Sr.				. Rondo					
TO B	19e. INFORMANT'S NAME (Type/Print)					oute Number, City or Town					
-	Rose M. Rudolph (Mo	other)	3715	Bonview	Avenue,	Baltimore,	Md. 27	1213			
	20e: METHOD OF DISPOSITION  1 G Burlal Cremetion 3 G Removal		PLACE AND DATE O				CATION — City or To				
	4 Donation 5 Other (Specify)  21. SIGNATURE OF FUNERAL-SERVICE LICENS		St Holy			1/2/95 Ba	etimore,	Marykana			
	► W			Schim	unek Fun	eral Home					
$\vdash$	23 PART I Fotor the diseases or some	milestians that accord				ane, Balti		1. 21213			
	23. PART I. Enter the diseases or com shock, or heart failure. List	only one ceuse on ee	ch iine.	ot antar the mod	ia of dying, such	as cardiac or respi	ratory arrest,	Approximata interval Between			
	iMMEDIATE CAUSE (Final disease or condition	RESOLVE	atomy	Fall	06			Onset and Death			
	resulting in death) a	DUE TO (OR AS A	CONSEQUENCE OF		180			17/24/8			
Z	Sequentially list conditions,	metasn	rtic	Rhal	domve	54020 FC	4	10mm2			
AŢ	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF	):							
윤	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	1:							
CERTIFICATION	resulting in death) LAST	,		,				į			
	PART II. Other eignificent conditions co	ontributing to death bu	A mad manufature to		Commission of the						
CAL	TATO II. Other organicant conditions of	billing to deet bu	it not rasulting ii	i the underlying	ceuse given in F	Part i. 24a. WAS AN A		MAILABLE PRIOR TO			
MEDIC						1 □ YES &	NO	OF DEATH?			
	DID TOBACCO USE CONTRIB	UTE TO CAUSE OF	DEATH YE	S I NO.	UNCERTAIN			1 NES 2 NO			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	2	6. PLACE OF CEAT		OTTOLKIANT						
YSIC		OSPITAL: Inpetient 2 ER/Outpe	tient 3 DOA	OTHER: 4  Nursing Home	5 Residence 8	Other (Specify)					
F	27. MANNER OF GEATH  Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU			26d. DESCRIBE HOW IN	JURY OCCURED				
BY	2 Accident Investigation	20° BLACE OF IN HIDY	A15	M 1 7							
ETED	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY - building, etc. (Specif	y)	reet, factory, office		281. LOCATION (Street a: City or Town, Stete)	nd Number or Rural i	Route Number,			
	29e, CERTIFIER 1 CERTIFYING PHYSICIAN	N: To the heat of my knowle	day of all			La riberta Marcas	-				
COMPL		N: To the best of my knowle on the beele of examination						e) and manner so stated.			
	29b. SIGNATURE AND TITLE OF CENTER	/			29c. LICENSE NUM		29d. DATE SIGNED				
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2	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF OEA	TH (ITEM 27) (Type,	Print)	7:1	4 1	11				
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within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	npletely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit	cremation, of removal.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNESTAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buria-transit permit	be med within 72 hours are read with the State Cept. of reading and wested hydrere prior to burid, cremation, or removal, and the sampler must be notified at once IMPORTANT. If them 28 is marked, or liem 23 shows any injury, or other trainfall event, the medical examiner must be notified at once
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH JAMES ROY MAY 4, 1995 05:00A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday IF UNDER 1 YEAR 7. DATE OF BIFTH (Month, Day, Year) IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 F DAYS 218-52-3262 YRS 46 3/1/39 Va 9a. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY N/ARESIDENCE OF DECEDENT 10a STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY N/AMd. Baltimore, Maryland 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3436 Auchentroly Terr. 21217 USA 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 NO 1 Never Married 2 Married BY 1 TES 2 NO Specify: Specify: 3 Widowed 4 Divorced Black COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5 +) 12th Laborer Construction (BG&E) 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) James Roy BE Mary Gertrude Daniels 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Eleanor Hubbard Menlo Drive Baltimore, 21215 Md. 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata OATE Burtal 2 Cremation 3 Re Cemetery crematory of other place) 4 Donatlon 5 Other (Specify) 5/9 Randallstown, MD M.L. King 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Leroy O. Dyett & Son Funeral Home 4600 Liberty Heights Ave. Balto, Md 21207 23. PART I. Enter the diseases or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, ahock, or heer failure. List only one ceuse or each line. Approximata Interval Between IMMEDIATE CAUSE (Finel Onset and Peath removica disease or condition weeks resulting in death) DUE TO (OR AS A CONSEQUENCE OF) ears retroveral M 6 CERTIFICATION Sequentielly liet conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II., Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? asculity 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO Inpstient 2 - ER/Outpstient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, strast, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide determined 29a. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as atsted. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) and menner as stated 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Worth, De BE Mileine MEDICAL RESIDENT 05 OL 2 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Johns Hopkins Hosp., 600 N. Wo

32. REGISTRAR'S SIGNATURE

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Item#17. G-film 723 per F.H 5/5/95 P.C FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH CAROLYN Elizabeth RICHTER MAY 1995 3:22 DM A SOCIAL SECURITY NUMBER 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 7. DATE OF BIRTH 213-28-2405 1 M 2 K F 81 June 15 Maryland Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH GREATER BALTIMORE MEDICAL CENTER RECTOR TOWSON BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Lutherville 5 1 YES XXX NO permit. FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? burial-transit 2111 Starmount Lane 21093 USA hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES X2X NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Maxican, Puerto Rican, atc.)
1 YES Y NO Specify: BALTIMORE, MARYLAND 21215-0020 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married B Specify: use as the t XX Widowed 4 Divorced White ETED. 15. DECEDENT'S EDUCATION 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe n by the funeral director, page 5 should be detached for Lerenoval. entary/Secondary (0-12) College (1-4 or 5 +) 12th grade COMPL Self Employed Amusement notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) Charles F. Burkhart Charles F. Bolkhart Elizabeth Minch BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Wayne Richter 2111 Starmount Lane Lutherville, Md. 21093 Pe 20a. METHOO OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — Cify or Town, Stata must ★□ Burial 2 □ Cremation 3 □ Re
 4 □ Donation 5 □ Other (Specify) ______ Parkwood Cemetery 5-4-1995 Baltimore, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Lassahn Funeral Home 401 Belair Rd. Baltimore, Md. the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such se cerdiac or respiratory strest, filled in by Approximata shock, or heart failure. List only one cause on 6 Interval Betw **IMMEDIATE CAUSE (Finsi** Onest and Death cremation, disease or condition resulting in death) Sclero and completely fi o burial, cremation 10 event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentielly list conditions, 2 DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate the attending physician Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Diseese or injury other OUE TO (OR AS A CONSEQUENCE OF): that initisted events resulting in death) LAST 6 injury, PART ii. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? Health and I 1 TES 2 NO OF DEATH? 1 ☐ YES 2 ☐ NO t. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) State certificate HOSPITAL: OTHER: 1 YES 2 NO Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specily) 6 the 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26b. TIME OF 26d. DESCRIBE HOW INJURY OCCURED with 1 marked, 1 Natural М 1 YES 2 NO BY After death 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 60 ETED. 6 Could not be DIRECTOR: after 4 Homicide 28 hours COMPL 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL
TO THE FUNERAL I
De filed within 72 h
IMPORTANT: If I (Check only one) 2 MEDICAL EXAMINER: On the of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and menner as stated. 296. SIGNATURE AND TITLE OF BERT 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 30. NAME AND ADORESS OF 10 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

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	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Flours after death. Page 6 may be	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director
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DR. WICKS, GE
31. DATE FILED (MOND Day York)
MAY U 5 1995

		FOR STATE REGISTRAR		STATE OF N	MARYLA			TMENT O			MEN	NTAL HYGIEN REG. NO.			
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- 1		4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In	vre las	historiau1	IF UNDER 1 Y		T I NAME OF LINE	-				
		220-01-415		1 X M 2 F	6. AGE (In	_	YRS.			OURS MIN.	1 1	Month, Day, Year)		Counti	
				•		Yno.	31 51774 700				ept 14,1			imore,MD.	
	OR	90. FACILITY NAME (If not institution, give street end number)  Fort Howard VA Hospital						Balt		re	EATH			nty of D ltim	
	DIRECTOR	RESIDENCE OF DEC	10b. COUNT	,			40. 017		TOWN OR LOCATION						
- 1	E I		N/A	•						N					10d. INSIDE CITY LIMITS?
		Maryland	-		_ :-	В	altimo		0.0005	_				1 X YES 2 NO	
	FUNERAL	3306 Brendan Avenue 21213										WHAT COUNTRY?			
	Ä	11. MARITAL STATUS 12. WAS DECEDENT_EVER				II C AD	MED	40 149 4						S.A.	
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- 1	B	3 Widowed 4 Divo	reed	Worl	d War	71.7		1 TES 2 NO Specify					Spec	white	
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at l	AP.	12th grade	- 177.5		P	olic	e Offi	cer			Balto. City Police Dept				
once.	ő	17. FATHER'S NAME (First, M							1	8. MOTHER'S NA	ME (F	Irst, Middle, Meiden	_		
7	BE (	Samuel Ser	io							Antoine	tt	e Pilach	owsk	í	
notified	10 8	19a. INFORMANT'S NAME (7	ype/Print)			198	. MAILING	ADDRESS (SI	reet and	Number or Rural i	Route	Number, City or Town	n, State, Zip	Code)	
	F	Barbara M.	Serio	(Wife)		3	306	Brenda	n A	venue,	Ва	altimore, Md. 21213			
st be		20a, METHOD OF DISPOSIT		oval from State	20b. P	LACEA	NDDATE	OF DISPOSITIO	N (Name	of		DATE 20c. LO	CATION -	Cify or To	wn, State
must		4 Donation 5 Other	(Specify)		- Ga	rris	son I	orest	VA	Cem. 5	15,	/95 Ow:	ings	Mill	s, Md.
nine		21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE						ADDRESS OF FA					
exan		11.	1	///.								ral Home ne, Balt		o M.	d. 21213
or removal. medical examiner		23. PART Enter the di	laeases, or o	complications that	t caused t	tha de	ath. Do n								Approximate
or re		shock, or heart failure. List only one cause on each line.													
		MMEDIATE CAUSE (Final disease or condition   Alcoholic Liver Disease with Ascites   Alcoholic Liver Disease with Ascites   Alcoholic Liver Disease with Ascites													
Mental Hygiene prior to burlal, cremation, ijury, or other traumatic event, the		resulting in death)  DUE TO (OR AS A CONSEQUENCE OF):													
rial, c	-	Alcohol Abuse													
or other traumatic	ON	Sequentially list conditi		D	(OR AS A C		UENCE OF	7:							
trac	X	cause. Enter UNDERLYI	NG												
the c	Ĕ	CAUSE (Disease or Inju that initiated events	ν )	DUE TO	(OR AS A C	ONSEO	UENCE OF	7:							
0 0	ERTIFICATIO	resulting in death) LAS	т 【 ,	d.											
injury,	O	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS													
i aud	SAL								lying c	ause given in	Part	I. 24a. WAS AN . PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
5 6 E	EDK	HIPERIE	NSTON,	CORONARY	AR'	TER'	Y_DIS	SEASE.				1 - YES 2	<b>X</b> NO		OF DEATH?
shows an	Σ														1 YES 2 XNO
23 s	SICIAN:	DID TOBACCO U	-	RIBUTE TO CA						UNCERTAIN	N [				
item 23 s	5	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	20	, PLACI	E OF OEAT	H (Check only OTHER:	one)						
2 5	HYS	1 TYES 2 NO		1 Minpatient 2		ient 3	□ DOA		Home	5 🗆 Residence	8 🗆	Other (Specify)			
e d	표	27. MANNER OF DEATH	Deading	28e. DATE OF (Month, De			28b. TIMI INJI		. INJURY		28d.	DESCRIBE HOW IN	JURY OCC	URED	
s marked	à l	1 Naturel 5 Pending 2 Accident Investigation M 1 YES 2 N					2 NO								
28 is marked,		3 Suicide 8 Could not be 4 Homicide datermined						281.	LOCATION (Street & City or Town, State)	nd Number	or Rural R	oute Number,			
item 28 i	ᇤ	/	atter mined												Variety in the
f item	김		IFYING PHYSIC	CIAN: To the beat of	my knowled	ige, des	th occurre	d at the time,	data en	d place, and due	to the	e ceuse(e) end men	ner ee atat	ed.	
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296. LICENSE NUMBER  296. LICENSE NUMBER  1 1 1 3 6 5											I	29d, DATE	SIGNED	(Month, Day, Year)	
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-	임	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF DEAT	H (ITEM	27) (Type,	Print)			_			/	,

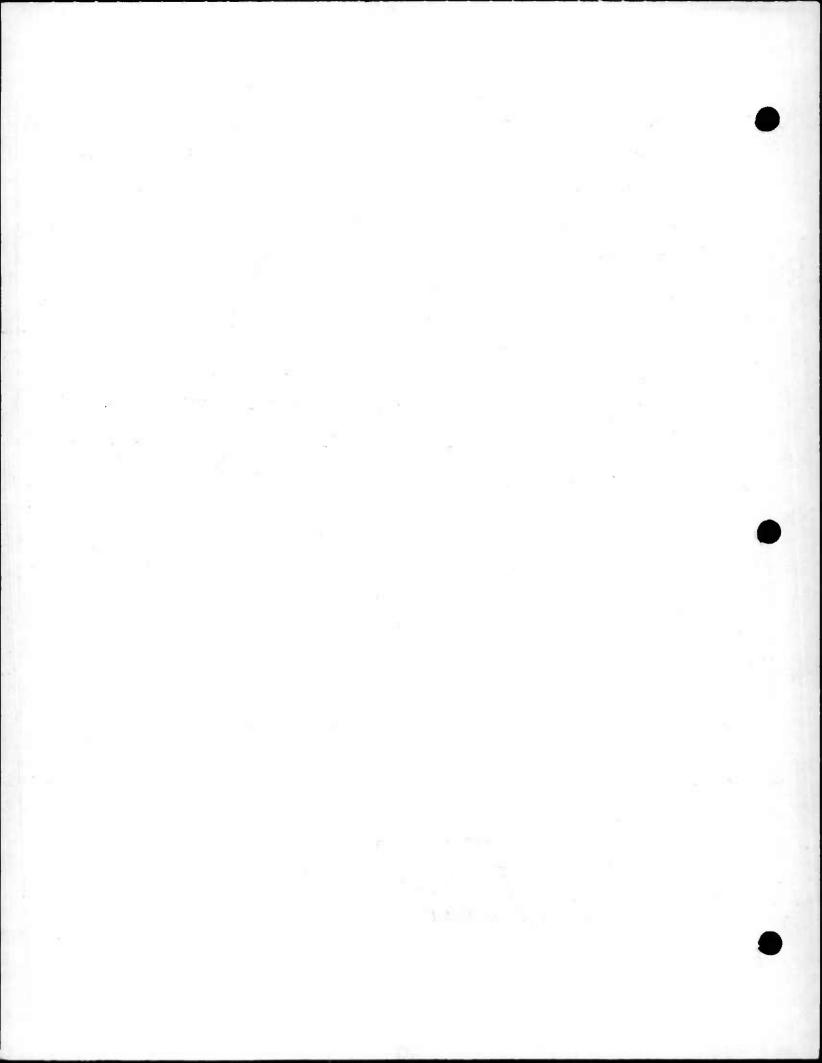
GEORGE III M.D. 9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND

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		1. DECEOENT'S NAME (First, Middle, La: ANN MARIE	SIMMONS		2. DATE MONT MA	OF DEATH	1995	EAR .	TIME OF DEATH			
P		4. SOCIAL SECURITY NUMBER 579–05–0608	1 M 2X F	E (In yrs. last birthday) 32 YRS.	IF UNDER 1 YE		7. DATE	OF BIRTH N. Day, Year) 08-191;			CE (State or Foreign	
. 2, 3 should	TOR	9a. FACILITY NAME (If not institution, gives 7421 PHELPS ROA RESIDENCE OF DECEMENT				WN OR LOCATION OF ANOVER	OEATH		9c. COUNT			
permit, Pages 1,	DIRECTOR	10a. STATE 10b. COU	NE ARUNDEL	10c. CI1	TY, TOWN OR LI					100	1. INSIDE CITY LIMITS? YES 2 NO	
1St	FUNERAL	10a. STREET AND NUMBER 7421 PHELPS ROA	D			101. ZIP CQOE 2107	6		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
215-0020 attending physician. se as the buria-transit	ВУ	11. MARITAL STATUS 1 Never Merried 2 Married 3 X Widowed 4 Divorced	FORCES? 1 TYE	DECEDENT EVER IN U.S. ARMED  DESCRIPTION OF HISPA  13. WAS DECENDENT OF HISPA  If yes, specify Cuber, Mask  1 YES 2 NO Spec				can, Puerto Rican, atc.) Black,			American Indien, hita, atc. WHITE	
	PLETED	15. DECEDENT'S E (Specify only highest gri Elementary/Secondary (0-12) 1 OTH	DUCATION ade completed)  College (1-4 or 5 +)  N/A	16e. DECEDENT'S (Give kind of life. Do NOT u	work done during se retired.)	PATION g most of working	168		SINESS/INDUSTRY  N HOME			
YLAND 21 by the hospital or be detached for u at once.	E COMPL	17. FATHER'S NAME (First, Middle, Last) FRANK EDWARD	PROCHAZKA	ПОМЕН	ARLIK	18. MOTHER'S I	Middle, Maiden					
E, MAR y be retained sage 5 should be notified	TO B	19a. INFORMANT'S NAME (Type/Print)  SHIRLEY A. COLLIGAN  19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, 7421 PHELPS ROAD, HANOVER, MARYLAI									5	
ALTIMORE, leath. Page 6 may be funeral director, page xaminer must be		206. PLACE AND DATE OF DISPOSITION  1 Surfel 2 Cremetion 3 Removal from State  206. PLACE AND DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DISPOSITION (Name of State And DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DATE OF DA										
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OX 68760 be executed within-24 hours cian and completely filled in to for to burial, cremation, or re- raumatic event, the medi-	RTIFICATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	a. DUE TO (OR AS  B. Rheuna  DUE TO (OR AS  Mulfi	Complications that caused the death. Do not enter the mode of dying, such as cardiac or reepiratory arrest,  List only one cause on each lina.  Approximate interval Between Onset and De.  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  Mulfi-Infact demands A								
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DIV DITHE HOSPITAL OR A TO THE FUNERAL DIREC DE filed within 72 hours IMPORTANT: If Ilem	TO BE COMPL	2 MEDICAL EXAMI	NER: On the beat of examinate William  Lie Inte.  WHO COMPLETED CAUSE OF 50	COMPLETE CAUSE OF GEAR WENG TO TYPE, Print)								
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Item 23 shows any injury,

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH FREDERICK SHANK 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS

1 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH APRIL 1995 20 1925 4. SOCIAL SECURITY NUMBER 8. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH (Month, Day, Year, 200-28-6403 ORK 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR CEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY BAUTIMORE YES 2 NO FUNERAL 100. STREET AND NUMBE 10g. CITIZEN OF WHAT COUNTRY? 2/200 11. MARITAL STATUS 12. WAS DECEDENT, EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuben, Mexicen, Puerto Rican, etc.) 1 Nover Married 2 Married 1 TYES 2 NO Specify BY Widowed 4 Divorced ETED 15. DECEDENT'S EDUCATION 18s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use refired.) 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) MACHINIST COMPL 17. FATHER'S NAME (First, Middle, Last) BE 19a, INFORMANT'S NAME (Type/Print) 2 TTOP 20e, METHOD OF DISPOSITION

1 Burlel 2 Cremation 3 20c. LOCATION - City or Town, State DATE 4 Donation 5 Other (Specify) 21. SIGNATURE OF NUMERAL SERVICE LICENSEE 23. PART i. Enter the diseases, ahock, or heert fellure. complicatione that caused the leath. Do not enter the mode of dying, euch as cardiec or respirete Approximate List only one ceuse on sech line. Intervei Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition_ CORDIOPULMONARY ARREST reculting in death) DUE TO (OR AS A CONSEQUENCE OF): PROBABLE PNEUMONIA CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury AIDS DUE TO (OR AS A CONSEQUENCE OF): that initieted evente reaulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 TES 2 NO 1 - YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN [X]X 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatlant 2X| ER/Outpatient 3 | DOA OTHER: YES 2 NO 4 Nursing Home 5 Reeldence 8 Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1X Natural Pending Investigation 1 YES 2 NO ΒY 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER 1X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and manner ee ateted. 2 ___ MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 4/20/95 D47046 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 22.S GREENE ST. BALTIMORE, MD 21210 District N



 UNK. 95-119

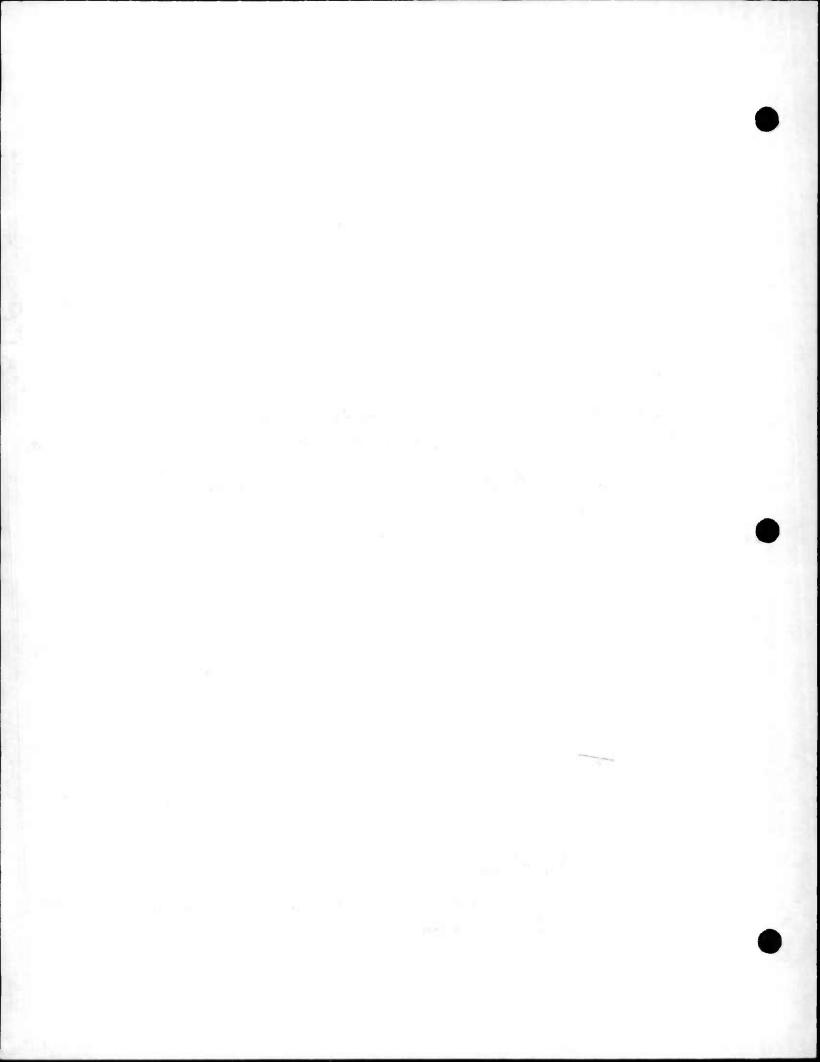
1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH GABRIELLE T. SCHUHART 1995 РМ MAY 01 9:23 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR 6. BIRTHPLACE (State or Foreig IF UNDER 24 HRS. HOURS 219-76-4756 1 M 2 X F 35 YRS. Maryland 1959 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR N/A BALTIMORE HESIOENDEROS DECEDENOSPITAL 10b. COUNTY 10c. CITY TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland N/A Baltimore 1 X YES 2 | NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. In and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit to burial, cremation, or removal. 3219 Montebello Ter. 21214 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: **BALTIMORE, MARYLAND 21215-0020**  RACE — American Indien, Black, White, stc. 1 Never Married 2 Merried Specify: White BY 3 Widowed 4 Divorced ETED. 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 4 Richard C. Schuhart BE Patricia Parr notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Patricia Schuhart 3219 Montebello Ter., Baltimore, MD 21214 9 20a, METHOD OF DISPOSITION
1 (X Burlel 2 Cremetion 3 Rem 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must Most Holy Redeemer Cem. 4 Donation 5 Other (Specify) 5/5 Baltimore, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ALTENBURG FUNERAL HOME, P.A. 6009 Harford Rd., Baltimore, MD 21214 medical 23. PART h Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between IMMEDIATE CAUSE (Final Onset and Death the disease or condition MARCOTIC AND ALCOHOL INTOXICATION resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate the attending physician Mental Hygiene prior to the death certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL n signed by the Health and N any 1 YES 2 NO OF DEATH? Shows 1 YES 2 NO t. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: OR ATTENDING PHYSICIAN: The law DIRECTOR: After this certificate has bhours after death with the State Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 XYES 2 NO 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 0 28e. DATE OF INJURY (Month, Day, Year) FOUND: 5/1/95 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? marked, 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 7:11 P M 1 YES 2) NO UNKNOWN BY 2 Accident 26e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, Stelle) 1508 W. PRATT ST. BALTIMORE CITY, ND. 3 Sulcide COMPLETED 6 XX Could not be 4 Homicide 28 HOUSE LOCATED AT item 29e. CERTIFIER

(Chack only

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. HOSPITAL FUNERAL WITHIN 72 h TY MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and menner as stated. TO THE HOSPIT TO THE FUNERA De filed within 7 MATURE AND TITLE OF CONTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE OCME MAY 02,1995 9 LETED CAUSE OF DEATH (ITEM 27) (Type, Print) 4 Del Dorto

111 Penn Street, Baltimore, Maryland 21201



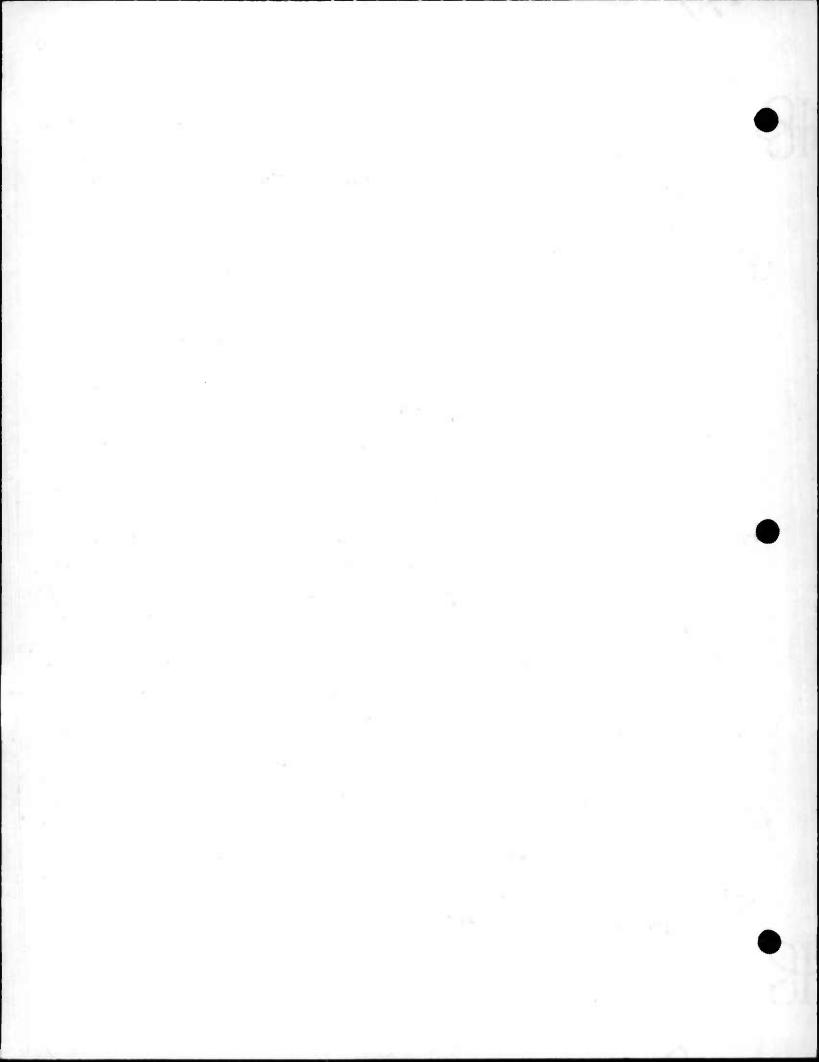
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DIVISION OF VITAL RECORDS. P.O. BOX 68760

F.O. BOX 60/84	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the flower after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detacthed for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
Civision of VIIAL RECORDS, P.O. BOA 86/60	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the de-	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the at be filed within 72 hours after death with the State Dept. of Health and Ment	IMPORTANT: It Item 28 is marked, or Item 23 shows any injury,

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAN				CENTIF	ICAI	E UF	DEA	IП	R	EG. NO.				
1	1. DECEDENT'S NAME (First	, Middle, Last) ames	Siney			2. DAT MON					DA		YEAR	3. TIME OF OEATH	
1 1	4. SOCIAL SECURITY NUMBER		5. SEX	0.100.0		day) IF UNDER 1 YEAR IF UNDER 24 HRS.			May 3,1995				5.15 P.H. H		
	217348374	DEN	1 M 2 F	8. AGE (In yrs. 57	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month Day	7. DATE OF BIRTH (Month, Day, Year)  Jan. 25, 1938		a. BIRTHPLACE (State or Foreign Country) Maryland		
	9a. FACILITY NAME (If not in	nstitution, give			9h CITY	V TOWN	OR LOCATI	ION OF OF		23,1		INTY OF O			
DIRECTOR	6401 Belai			D 1. 1				I/A	EAIR						
5	RESIDENCE OF DEC														
#	10a. STATE	N/A	Y			Y, TOWN								10d. INSIDE CITY LIMITS?	
1 1	Maryland 100, STREET AND NUMBER		Ва	altin			Lity					1 X YES 2 NO			
FUNERAL	6401 Bela		101. ZIP CODE 21206					U.S.A.							
13	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S.	ARMED	13.	WAS DEC	CENDENT (	OF HISPANI	C ORIGIN? (Sp	acify Van	or No			
	1 Never Married 2	YES 2	YES 2 NO If yes,			pecify Cuba	nn, Mexican	, Puerto Rican	, atc.)	01 140-		E — American Indian, k, White, atc.			
ВУ	3 Widowed 4 Divo	orced	IF TES, GIVE T	MR OR DATES	OR OATES 1 ☐ YES XX NO Specify:					Specify: White					
E	15. OEC (Specify onl	EDENT'S EOU y highest grade	CATION completed)	16a.	Give kind of life. Do NOT u	USUAL O	CCUPATION OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE COURT OF THE C	ON ost of workli	ng	16b, KIN	D OF BUS	INESS/IN	DUSTRY		
COMPLETED	Elementary/Secondary (I	0-12)	College (1-4 or 5-4yrs.	") c	ollect					Stat	e Go	vern	ment		
NO.	17. FATHER'S NAME (First, M	liddle, Last)	.,,					18. MOT	HER'S NAM	IE (First, Middle	, Maiden :	Surname)			
BE	Jerome Fer		d Siney							Unkn					
2	19a. INFORMANT'S NAME (				19b. MAILING	ADDRES	S (Street i	and Number	r or Rural Ro	oute Number, C	ity or Town	, State, Zip	p Code)		
F	Lisa A. Sin									bingdo	n,Ma	ryla	nd2	1009	
	20a. METHOD OF DISPOSIT 1 X Burlai 2 Cremetic	n 3 🗆 Rem	novel from State	20b. PLAC							20c. LOC	CATION —	City or To	wn, Stata	
	4 ☐ Donation 6 ☐ Other  21. SIGNATURE OF FUNERA		CENSEE	_ [Gard	ens of		POSITION (Neme of 5/6/95 OATE 20c. LOCAT aith Cemetery Balti					imore, Maryland			
	+K-11	/	In he	/	/									Road d21206	
$\vdash$	23. PART 1. Enter the d	Iseases, or	complications the	t chused the	death Do										
	snock, or n	eart lenure.	List only one ceu	ise on each i	ine.		> \	/	, soci	as cardiac	oi respii	etbiy air	reat,	Approximete Interval Between	
	IMMEDIATE CAUSE (Fir disease or condition	nel	- Lle	norca	200	X	Zs!	wi	us				20	Onset and Death	
1 1	resulting in death)  DUE TO (OR AS A CONSEQUENCE OPT)									24/100					
z	- HO. alcoholism your										years				
E	Sequentielly list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):									2000					
2	CAUSE (Disease or Inju		c CO	(OR AS A CON	cu	oce	you	m	12				_	gues.	
CERTIFICATION	that initiated events resulting in death) LAS	т		(OH AS A CON:	SECUENCE O	-									
1 11	51 FF II OU 1 10		σ												
MEDICAL	PART II. Other significe	ondition	ns contributing to	death but no	t resulting	In the ur	nderlyin	g cause (	given in P	art i. 24s.	WAS AN		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
ğ										_   10	YES 2	NO		DF OEATH?	
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AN	DID TOBACCO U		KIBUIE IO CA						ERTAIN						
豆	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:		LACE OF DEA	OTHE			/						
PHYSICI	1   YES 2 NO		1   Inpatient 2						sidenca 6	Other (Spe	ecify)				
		Pending	28a. DATE OF (Month, D		26b. TIM	E OF JURY M	WO	JURY AT ORK? YES 2		28d. DEŞCRIB	E HOW IN	JURY OC	CURED		
D BY	3 Suicide 6	Could not be	28a. PLACE O	F INJURY — At etc. (Specify)	home, term,	street, fact	tory, offic	20		281. LOCATION City or Tox		nd Number	r or Rural F	loute Number,	
ETE		determined	5007555			-				Oily Or Ion	vii, State)				
립	(Check only	IFYING PHYS	ICIAN: To the best of	my knowledge,	death occurr	ed at the t	lme, data	and place	, and due to	o the cause(a)	and man	ner as stat	ted.		
29a. CERTIFFIER 1 CRETIFFIER 1 CERTIFFING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.  One)  2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and									) and manner as stated.						
ш	29b. SIGNATURE AND TITLE	OF CERTIFIE	Je/is	. A		-		29c. LICE	ENSE NUME	BER OJ		29d. DAT	E SIGNED	(Month, Day, Year)	
TO B	cer	1	1	2				DO	0-	187		ل ﴿	-4	1-1885	
	CARLOS E.	ARA	NAGA 14	D. 3	TEM 27) (Type)	Print)	retil	m 1	arto	by B	allo	: 14	1.2	2/2/4	
	31. DATE FILED (Month, Day,	55 Ju	Li DESETTA	a Clerkhil	E	- / / /	A.		- 000	111		// "			
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

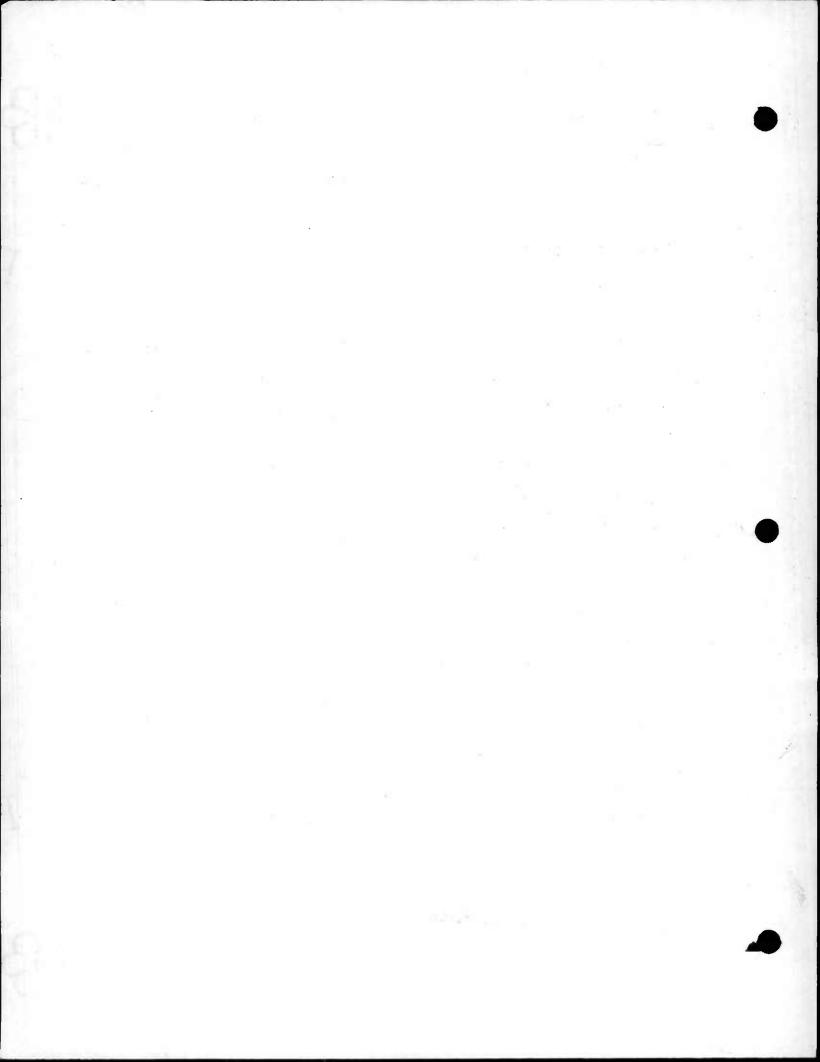
TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-54 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Ilem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

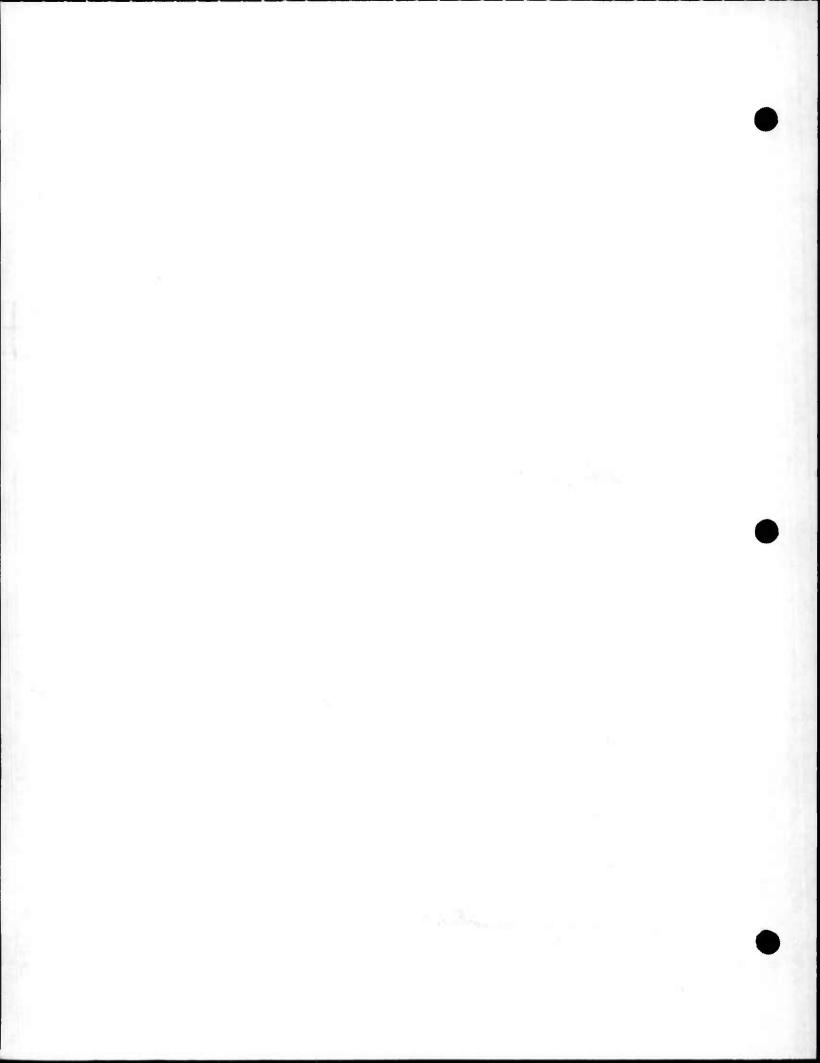
	VICEIOTIBUT				OLINI	IFICAT	E OF	DEA	חו		REG. NO.			
	1. OECEOENT'S NAME (First GEORGE	, Middle, Last) CURNE	Y THO	MAS						2. DATE OF MAY	DEATN DA	19	95 ^{EAR}	3. TIME OF DEATH 2:30 P. M
	4. SOCIAL SECURITY NUME		5, SEX		yrs. last birtho	MONTHS	R I YEAR	IF UNDER	R 24 HRS.	7. DATE OF (Month, De	BIRTH N. Year)		8. BIRTI	NPLACE (State or Foreign
	215-18-584		1 🔀 M 2 🗆 F		75 YR	S.				JUNE JUNE	13,	1919	MAR	ÝLAND
æ	9a. FACILITY NAME (If not in ATLANTIC G					9b. CIT	Y, TOWN	OR LOCATI	ON OF DE	ATH			NTY OF E	
임	RESIDENCE OF DEC							7.1.4				VV	ORCE	SIEK
<u> </u>	10a. STATE	10b. COUNTY	,		10c.	CITY, TOWN	OR LOCA	TION						10d, INSIDE CITY
DIRECTOR	MARYLAND	ANN	E ARUNDEI			GLEN	BUR	NTE						LIMITS?
A	10e. STREET AND NUMBER							1. ZIP COD	E			10g. CIT	IZEN OF	WHAT COUNTRY?
FUNERAL	1106 SUNNY	BROOK	DRIVE					21	060			U	S.A	
5	11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER IN U	S. ARMED	13.	WAS DE	CENDENT C	OF HISPAN	IIC ORIGIN? (S	pecify Yes	or No	14. RAC	E American Indian, k, White, etc.
BY F	1 Never Married XX 3 Widowed 4 Divo		IF YES, GIVE W				1 Yes, sp	2 NO	In, Maxicai Specify	n, Puerto filca	n, etc.)		Spec	k, White, etc.
														WHITE
Ē	15. OEC (Specify only	EDENT'S EDUC y higheat grade	CATION completed)	16	(Give kind	T'S USUAL (	during mo	ON ost of working	ng	16b. KII	ND OF BUS	INESS/INC	DUSTRY	
COMPLETED	Elementary/Secondary (0	1-12)	College (1-4 or 5 +	•)		T use retired.)								
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8	17. FATHER'S NAME (First, M JAMES	action.	THE COLUMN C							ME (First, Midd	le, Malden	Sumame)		
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2	MILDRED A.		~							Route Number,				
	20a. METHOD OF DISPOSIT								DRIVE		v			RYLAND 21060
	1 Burial 2 Crematio	n 3 🗆 Rame	oval from State	206. PL cemete	LACE AND DA	TE OF DISPO	SITION (NO EMET	ERY		5/5/ 1995		CATION —		ARYLAND
	21. SIGNATURE OF FUNERA	SEMECE LIC	ENSEE			22.	NAME A	ND ADDRE	SS OF FAC	CILTYCIN	CI EUV	וים וווכ	INTERD	AL HOME,
	1 St.	2	1			-4.		OTAL Y	-7 A TOTAL	JE, Š. MARYLA	VV -		JINE:IV	an none,
	23. PART I. Enter the di	seesea, or c	omplications that	t ceused th	he death. D								rest,	Approximate
	IMMEDIATE CAUSE (Fin	eert tellure.	Liet only one ceu	se on eecl	h iine.									Interval Between Onast and Death
	disease or condition	<b>—</b>	Veni	hrice	las	Bast.	1.1	him	100					Boll /INI
- 1	resulting in death)		OUE TO	(OR AS A CO	ONSEQUENC	E OF):	4/1	vyn	(d.)					our week)
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CERTIFICATION	Sequentielly list conditi if any, leading to imme-	diete	DUE TO	QA AS A CO	ONSEQUENC	E OF):	1	1	•					
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E	that initiated events		DUE TO	OR AS A CO	DISEQUENC	E OF):								
EH	resulting in deeth) LAS	' L.	1											
	PART II. Other eignifice	nt condition	contributing to	death but	not recuiti	ng in the u	nderivin	G Ceuse (	given In t	Part I. 24	. WAS AN	MITOPSY	246	. WERE AUTOPSY FINDINGS
AEDICAL	11/1	1/Ho	il Mu	. /	ma	_					PERFOR	MED?	.   240	AVAILABLE PRIOR TO COMPLETION OF CAUSE
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-	DID TOBACCO U	SE CONITE	DIRLITE TO CA	IISE OF I	DEATH	VEC 🗆	NO F	111110	EDTAIL					1 TES 2 NO
AN	25. WAS CASE REFERRED TO		ADDIE TO CA			TES L		UNC	ERTAIN	, L				
Sic	EXAMINER?		HOSPITAL:			OTHE	R:							
PHYSICIAN	27. MANNER OF DEATN		28a. DATE OF			TIME OF	28c. INJ		sidenca	6 Other (Sp 26d, DESCRI		LILIEN OC	CIDED	
BY PI	1 Natural 5	Pending Investigation	(Month, De		100	INJURY M	WC	PRK?	] NO	-ve. DEŞUMI	L HOW IN	JOHT UC	OUNED	
	2 Suleide	Could not be	26s. PLACE OF	F INJURY —	At home, fer	m, street, fac	tory, offic			28f. LOCATIO		nd Number	or Rural F	Route Number,
COMPLETED		determined	ounging,	etc. (Specify)					- 1		wn, State)			
7	29a. CERTIFIER (Check only	IFYING PNYSIC	CIAN: To the best of	my knowledg	ge, death occ	urred at the	time, data	and place.	and dua	to the causels	) and men	ner as stat	ed.	
OM														) and menner as stated.
E C	296. SIGNATURE AND TIPLE	·	_						NSE NUM					(Month, Day, Year)
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2	30. NAME AND ADDRESS OF											_		
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	4. SOCIAL SECURITY NUM		5. SEX 1 (X) M 2 □ F	8. AGE (In yrs.		IF UNDER 1 YEAR		4 HRS.	7. DATE OF	F BIRTH Day, Year)		8. BIRTN Country	PLACE (State or Fore
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BEC	Charles A.		ann						P. Mi		Surrenney		
2	19a. INFORMANT'S NAME (		21.4			ADORESS (Street						Code)	
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OUE TO d	(OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS A CONS  (OR AS	EQUENCE O  EQUENCE O  EQUENCE O  EATH YI  ACE OF OEA  28b. TIM IN.	F):  F):  In the underly  In (Check only or OTHER: 4   Nursing N BE OF 28c.   FURRY M 1   street, factory, of odd at the time, di	UNCE    UNCE   Proprieta   Proprieta	RTAIN NO dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to dence to den	Part I. 2  Other ( 28d. DESCI  City or	24e. WAS AN / PERFORM PERFORM 1   YES 2  Specify) RIBE NOW IN ION (Street at Town, State)	AUTOPSY MEO?  JURY OCC  Ind Number  Iner as state  If due to the	24b.  CUREO  or Rural R  ed.  e cause(a)	WERE AUTOPSY FING AMAILABLE PRIOR TO COMPLETION OF CALL OF DEATH?  1 YES 2 NO



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

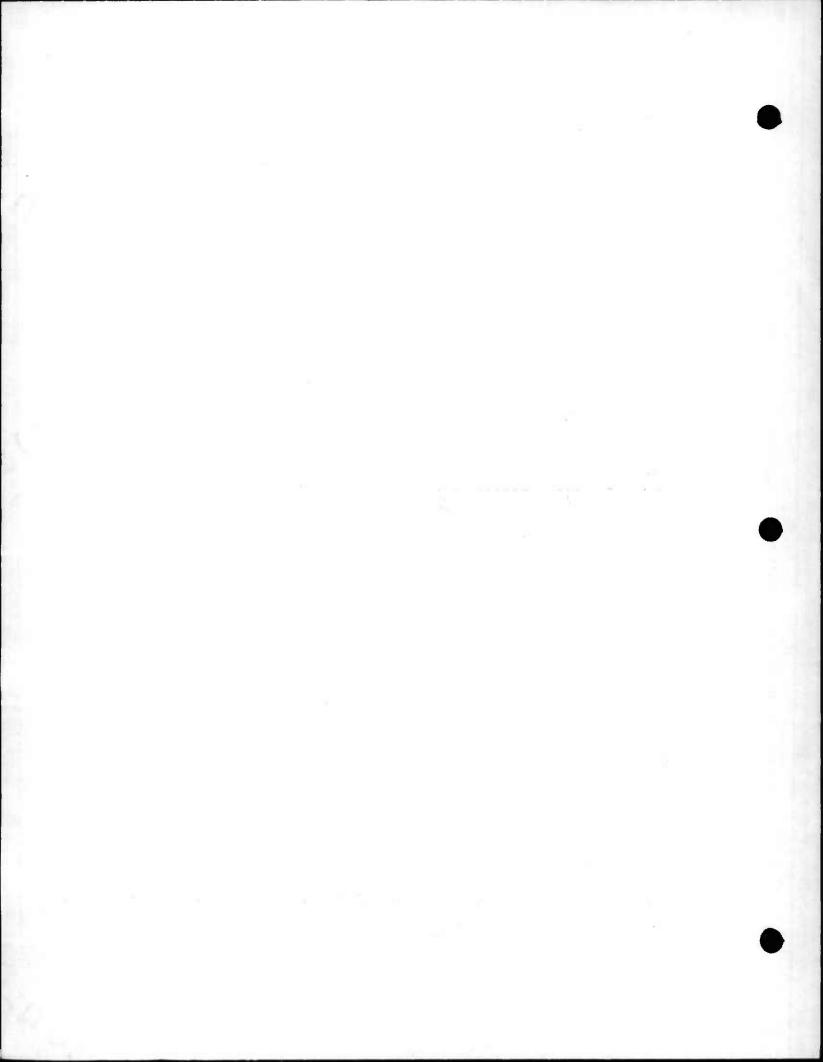
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

									99	13451
	1 - STATE REGISTRAR	STATE OF I				HEALTH AND	MENTAL	HYGIEN REG. NO		
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE O	OF DEATH		3. TIME OF DEATH
	MARGARET		VOLFF				MAY	3,	199	5 7:33 A
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. le:	st birthday)	IF UNDER 1 YEA	R IF UNDER 24 HRS.	7. DATE C			BIRTHPLACE (State or Foreign
	214-74-5510	1 🗌 M 2 😡 F	91	YRS.	MONTHS DAY	B HOURS MIN.	(Month,	Day, Ybar)		Country)
	9a. FACILITY NAME (If not institution, give str	reet and number)	91		9b CITY TOW	N OR LOCATION OF D	ISept	. 24,	9c. COUNTY	Maryland
Œ	7107 CHAMBERS	ROAD				'IMORE C			SC. COUNTY	OF DEATH
	RESIDENCE OF DECEDENT			_	DALI	IMORE C	111		N	/A
DIRECTOR	10s. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR LO	CATION				10d. INSIDE CITY
	Maryland N/A				Balti	more				LIMITS?
4	10a. STREET AND NUMBER					10f. ZIP CODE			10g. CITIZEN	OF WHAT COUNTRY?
FUNERAL	7107 Chambers Rd	•				2123	4		111	SA
15	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AF	RMED	13. WAS 0	ECENOENT OF HISPA	ANIC ORIGIN?	(Specify Yes		RACE — American Indian, Black, White, etc.
	1 Never Married 2 Married	IF YES, GIVE V	YES 2 X	NO	If yes,	specify Cuban, Maxic 'ES 2 X NO Spec	an, Puerlo Ri	can, etc.)		Black, White, etc. Specify:
ВУ	3 🕅 Widowed 4 🗌 Divorced						.,			White
	15. DECEDENT'S EDUC. (Specify only highest grade of	ATION completed)	16a. DE	ECEDENT'S	USUAL OCCUPA	TION most of working	16b.	KIND OF BU	SINESS/INOUS	TRY
	Elementary/Secondary (0-12)	College (1-4 or 5	) iño	Do NOT u	work done during se retired.)	most or working				
₽ P	Unknown			Sales	person		De	eparti	ment St	ore
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S N	AME (First, M.	iddle, Maiden	Surname)	
H	Charles Coleman I	Purcell				Emma I	rene l	Norris	3	
2	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	AOORESS (Street	et and Number or Rural	Route Number	er, City or Tow	n, State, Zip Co	de)
-	Doris Gochnauer		4	4101	Loch Lo	omond Dr.	, Bali	timore	e, MD	21236
1 1	20s. METHOD OF DISPOSITION 1 Durist 2 X Cremation 3 Ramon	uml forum State	20b.PLACE	AND DATE	OF DISPOSITION		OATE			or Town, State
	4 Donation 5 Other (Specify)	vai irom state	Green		int Crei	natory	5/5	Ra1	Ltimore	A. MD
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE			22. NAME	AND ADDRESS OF F				.7 100
	A Man	911. T				VBURG FUN				
$\vdash$	23 PART I Enter the disease or or	ullen	run		16009	Harford	Rd., I	Baltin	nore, N	ID 21214
	23. PART I. Enter the diseases, or co shock, or heart failure. L	iat only one ceu	ise on each line	eath. Do i	not enter the i	mode of dying, suc	ch ss csrdi	ec or respi	ratory srrest	, Approximata Interval Between
	iMMEDIATE CAUSE (Finsi disease or condition				5.					Onset and Death
}	resulting in desth) s					liovascu	lar 1	Disea	ase	
		DUE TO	(OR AS A CONSE	OUENCE O	F):					
8	Sequentially list conditions,									
CERTIFICATION	if sny, lesding to immediate cause. Enter UNDERLYING	DUE TO	OR AS A CONSE	OUENCE O	F):					
길	CAUSE (Disease or injury C.	DUE TO	/00 10 1 00 I							
E	that initiated events resulting in death) LAST	DOE 10	(OR AS A CONSE	OUENCE O	F):					
浜	d.									
i . ii	PART ii. Other significant conditions	contributing to	death but not r	resulting	In the underly	ing cause given in	Part I.	24a. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS
MEDICAL								PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE
								1 TYES 2	Ιχνο	OF DEATH?
Σ	DID TOBACCO USE CONTR	IRLITE TO CA	LICE OF DEA	TU V	CI NO	N LINICEDTAL				1 YES 2 NO
A N	25. WAS CASE REFERRED TO MEDICAL	IBUTE TO CA			H (Check only or		иП			
i iii	EXAMINER?	HOSPITAL:			OTHER.					
PHYSICIAN:	27. MANNER OF DEATH	1 Inpetient 2 I				ome 5X Residence				
	1 Natural 5 Pending	(Month, D		28b. TIM INJ	URY	NJURY AT WORK?	28d. DESC	RIBE HOW II	NJURY OCCUR	£D.
B	2 Accident Investigation	24- 84-405-0	F 44 4 1944			YES 2 NO	<u> </u>			
0	3 Suicide 8 Could not be datarmined	building,	F INJURY — At ho etc. (Specify)	me, term, i	mreet, factory, of	Tica	28f. LOCAT	Town, State)	nd Number or F	Rural Route Number,
Li I										
릴	29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICI	AN: To the best of	my knowledge, de	ath occum	ed at the time, d	ata and place, and du	a to the caus	e(s) and men	ner as stated.	
COMPL	2XXMEDICAL EXAMINER	On the basis of a	camination and/or	Investigatio	n, in my opinion	, death occured at the	e time, date e	nd place, en	d due to the ca	use(s) and mannar as stated.
шШ	PHE SIGNATURE AND TITLE OF CONTINER	11	/11-	1		29c. LICENSE NU	MBER		29d. DATE SI	GNEO (Month, Day, Year)
100	farit 28	W.	111	/		O.C.M	L.E.			4,1995
2		COMPLETED CAU	E OF DEATH (ITE	M 27) (Type,	Print)					
	MARIN F GOLL	5. TR &	Kh 111	Pen	n Stre	et, Bal	timo	re, M	Maryla	and 21201

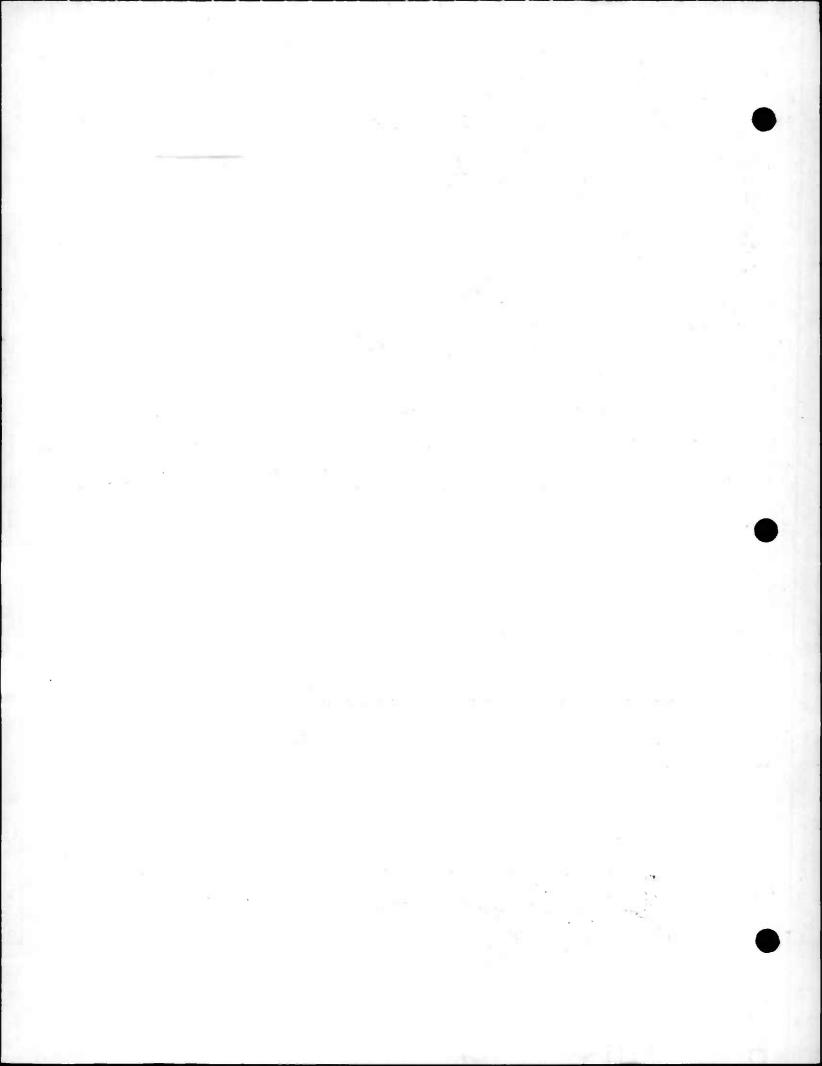
DHMH-16 Ray 1/89



REG. NO.

OECEOENT'S NAME (First, Middle, Last 2. DATE OF DEATH 3. TIME OF DEATH ICTOR 0 0 34 M 4. SOCIAL SECURITY NUMBER 5 SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH 8. BIRTHPL ACE (State or Foreign 463-38-0312 Texas wurs after death. Page 6 may be retained by the hospital or attending physician. In by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institu 96. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH 8559 DIRECTOR DeverN IDNEET RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Anne Arundel Severn 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8559 Pioneer Drive 21144 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1X YES 2 IF YES, GIVE WAR OR DATES 1 Never Married 2 Merried BY 1 YES 2 X NO Specify Specify: 3 Widowed 4 Divorced 1954-1974 White 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INOUSTRY (Give kind of work done life. Do NOT use retired.) Elementery/Secondery (0-12) College (1-4 or 5+) Army Officer Military 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) John Joseph Welfl notified at Helen Marie Kile BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Victoria Lilly 1174 Goldfinch Lane, Millersville, MD 21108 pe 200. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of May 6 DAGE5 20c. LOCATION - City or Town, State must 1 Buriel 2 Cremetion 3 Removal from State Metro Crematory, Inc. Catonsville, Maryland examiner 22. NAME AND AODRESS OF FACILITY
Kirkley-Ruddick Funeral Home, P.A. n by the fi 421 Crain Hwy., S.E., Glen Burnie, MD 21063 medicai filled in by 23. PART I. Entar tha diseases, or complications that caused the dasth. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate ahock, or haart failure. List only one cause on each line 0 interval Between IMMEDIATE CAUSE (Finsi **Onaet and Daath** and completely fille burial, cremation, the disease or condition resulting in death) LVD traumatic event, TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremIMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event DIVISION OF VITAL RECORDS, P.O. BOX 68760, TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 TES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO | PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: YES 2 NO 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28e. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED Natural 2 Accident 5 Pending ΒY 1 YES 2 NO 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide Could not be COMPLETED 4 Homicide 29e. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end menner ee steted. the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the causa(e) and menner se stated. SIGNATURE AND TITLE OF CERTIFIER 29d, DATE SIGNED (Month: Day Year) BE 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) mo 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 0 5 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



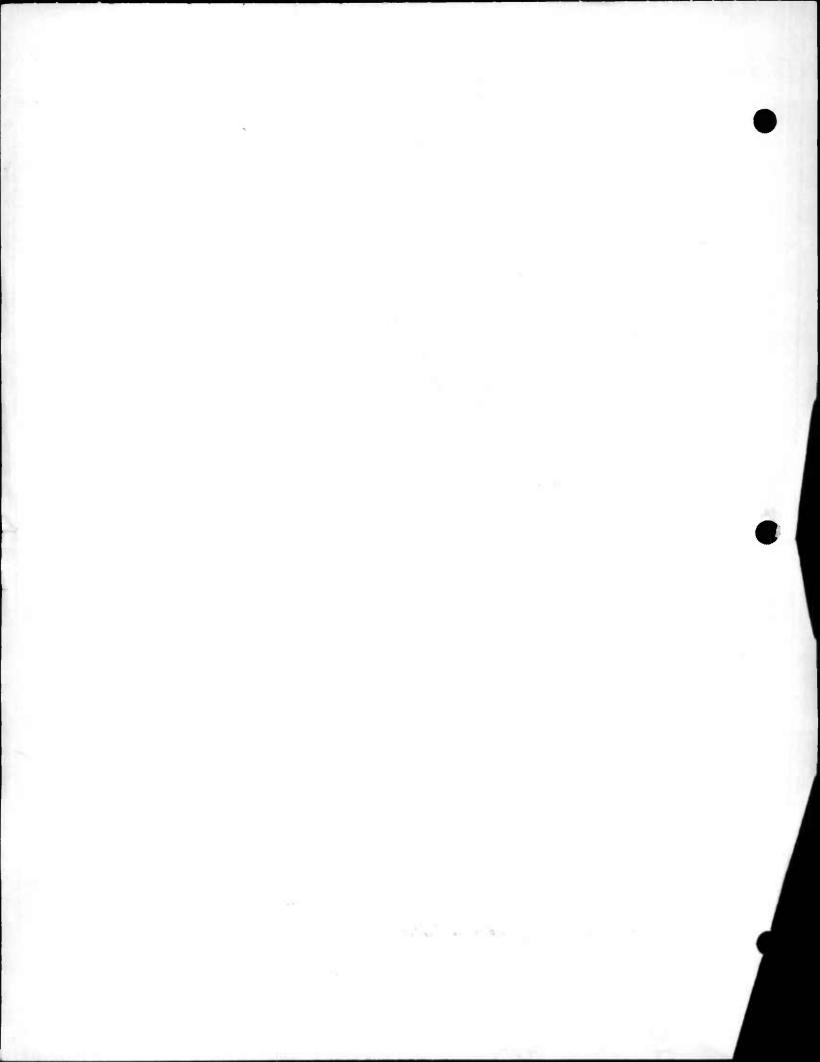
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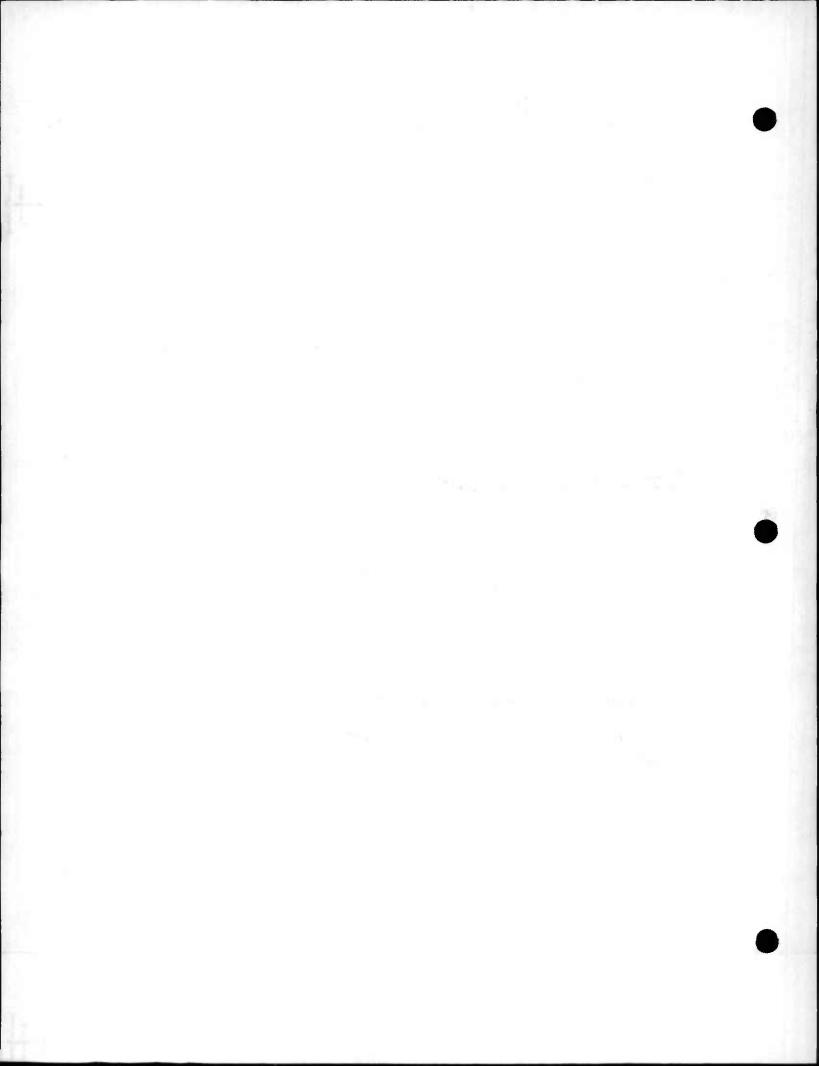
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG NO.

	1. DECEDENT'S NAME (First	Addedada Land				IOAII		DEA	***	_	HEG. NO			
	Richard		Steadman					-	,	2. DATE C		AY	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yrs. las	4 h/46 d = 1	-	tus	FIN		ATA	16 1	0.19		0044 M
	216-90-336		1 GM 2 GF		YRS.	IF UNDER	DAYS	HOURS	R 24 HRS. MIN.	7. DATE O	Day, Year)	1071	Countr	
	9a. FACILITY NAME (If not in			24	ina.						ry 15,			aryland
œ			THE COURSE OF	T onlimn	D			OR LOCAT		EATH			TY OF D	
5	PENINSULA		IAL MEDICA	AL CENTE	K	Si	ALIS	BURY				W	ICOM	IICO
DIRECTOR	10e. STATE	10b. COUNT	TY		10c. CIT	ry, town (	OR LOCA	TION						10d. INSIDE CITY
	Maryland	Wic	comico			Eden							_	LIMITS?
AL	10e. STREET AND NUMBER						10	. ZIP COO	E			10g. CITI	ZEN OF W	HAT COUNTRY?
FUNERAL	5175 Coope	r Rd.						21	822				USA	
5	11. MARITAL STATUS			T EVER IN U.S. AR		13.	WAS DEC	ENOENT (	OF NISPAI	NIC ORIGIN?	(Specify Yes	or No-	14. RACE	— American Indian, , White, atc.
BY	1 Never Married 2   3   Widowed 4   Divo		IF YES, GIVE Y		••			2 🔀 NO			can, etc.)		Specif	ly:
		EDENT'S EDU	ICATION	1 40 - 05	CEDENTIO	1 1001141 0							Whi	ite
	(Specify only	y highest grade	e completed)	(G	ive kind of Do NOT u	work done se retired.)	during mo	ost of world	ing	16b,	KIND OF BU	SINESS/INO	USTRY	
COMPLETED	Elementary/Secondary (0	1-12)	College (1-4 or 5	+)		Sal					Hard	ware	Stor	
8	17. FATNER'S NAME (First, M	iddle, Last)				Dul	-	18 MOT	HED'S NA	ME (Elect AA	iddle, Maiden		5001	. е
	Richard	S. A	Austin								cca D		7	
BE	19a. INFORMANT'S NAME (7	ype/Print)		190	b. MAILING	AOORES	S (Street a		_		or, City or Tow	2		
2	Richard & :	Nancy	Austin								2182			
	20a, METNOD OF DISPOSITI			20b. PLACE	ANDDATE	OF DISPOS	ITION (N			DATE		CATION - C	City or Tox	wn, State
	4 Donation 5 Other	(Specify)		- cemetery, cre Alle	n Ce	mete:	rv			4/12		len,		
- 1	21. SIGNATURE OF FUTERA	L SERVICE LI	CENSEE			22.	NAME A	ND ADDRE	SS OF FA	CILITY				
	146	7 4	fallin.	m I						eral		iahum	N	ID 21801
	27 PAN L Enter the di	seases, or	complications tha	t caused the de	ath. Do	not enter	the mo	de of dy	IIII	t an cordi	, sai	ISDUI	у, г	Approximeta
	snock, or no	eart failure.	List only one can	eech line	1.			11 T. T.				and the same	Date,	interval Between
	MEDIATE CAUSE (Findisease or condition	iai							1	agus				Onset and Death
	resulting in death)		DUE TO	(OR AS A CONSEC	DUENCE O	F):		-	7 6	rpus				~ 12100
z			h											i
CERTIFICATION	Sequentially list conditi if any, leading to immed		DUE TO	(OR AS A CONSEC	DUENCE O	F):								
S	cause. Enter UNDERLY! CAUSE (Disease or Inju		c											
	that initiated events resulting in death) LAS		DUE TO	(OR AS A CONSEC	DUENCE O	F):								
<b>#</b>	Tooditing in death) CAS		d											
	PART II. Other algnifice	nt condition	ns contributing to	deeth but not r	eaulting	in the un	deriyin	g ceuse :	given in	Part I.	24a. WAS AN		24b.	WERE AUTOPSY FINOINGS
MEDICAL											PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
		_								_	1   YE\$ 2	XNO	- 1	OF DEATH?
_ "	DID TOBACCO U	SE CONT	RIBUTE TO CA	USE OF DEA	TH Y	ES 🗆 I	NO [	1 UNC	ERTAIN					I TES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?					TN (Check								
Sic	1 YES 2 NO		HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER 4 Nun		e 5 🗆 Re	sidenca	6 Other	(Specify)			
E	27. MANNER OF OEATH		28a. DATE OF (Month, D		26b, TIM	E OF JURY	28c. INJ	URY AT		28d. OEŞC	RIBE HOW II	NJURY OCC	URED	
B		Pending Investigation				М		YES 2	] NO					
		Could not be	28e. PLACE O building,	F INJURY — At ho etc. (Specify)	me, lerm,	street, fact	ory, offic	0		28f. LOCAT	TION (Street a	and Number	or Aural A	oute Number,
Ë I	4   riomicide	determined												
COMPLETED	29a. CERTIFIER 1 CERT	IFYING PNYS	ICIAN: To the best of	my knowledge, de	ath occurr	ed at the t	lme, data	and place	, and due	to the caus	e(s) end man	ner se state	ıd.	
§ ∥	one) 2 MEDI	CAL EXAMINE	ER: On the basis of a	tamination and/or I	nveatigatio	on, in my o	pinlon, d	eath occur	red at the	Ilme, date a	nd place, en	d due to the	cause(s)	and manner ee stated.
BEO	296. SIGNATURE AND TITLE	OF CERTIFIE	A					29c. LICI	ENSE NUA	MBER		29d. DATE	SIGNED	(Month, Day, Yber)
	Tucheno	Level	مص					DSG	5100	2		Þ4.	10.9	5
유	30. NAME AND AODRESS OF	PERSON WH	O COMPLETED CAUS	SE OF DEATH (ITE	1 27) (Type	, Print)								
	lus Puz	Rint	# Road.	· Soliba	7. C	MO. 7	5.901	. •	m11	CHAG	C CR	oncH		
	APR 1	100c	32 HEGISTRA	R'S SIGNATURE	1 .									
	711/10	1332	Jana ala	nedat. May	44									



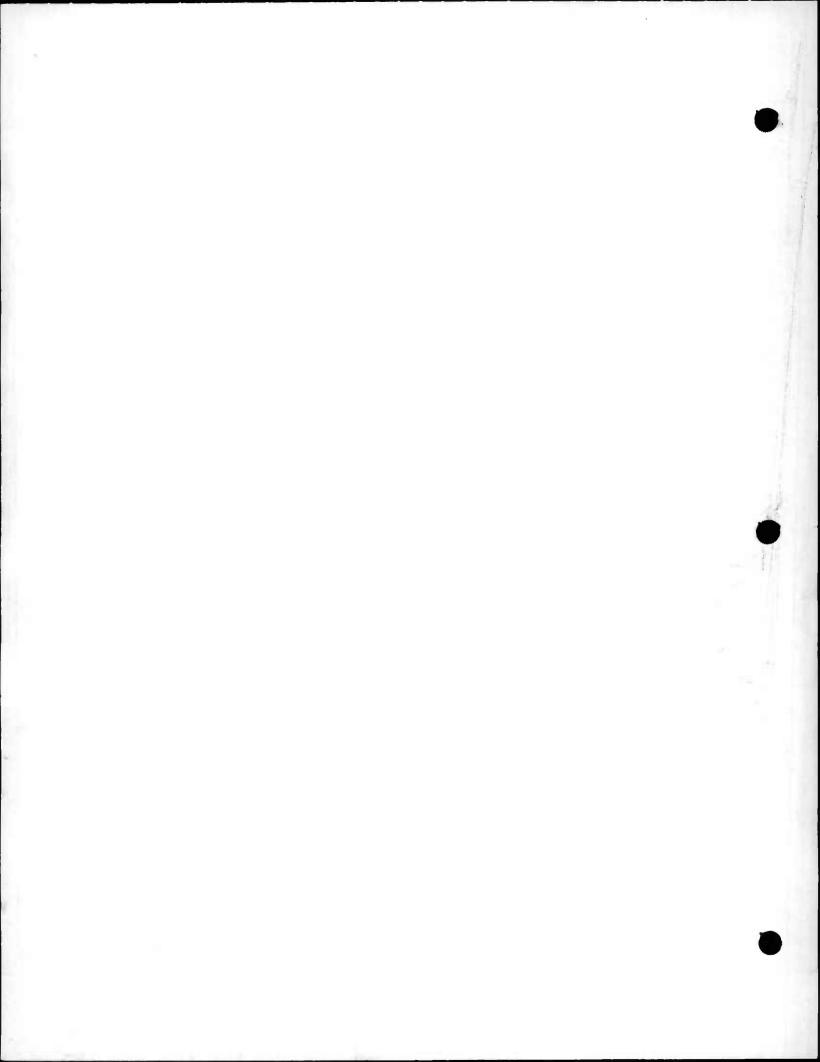
		1 - STATE REGISTRAR	STATE OF MARY	LAND / DEF	PARTMENT IFICATE	OF HEALT	H AND N		YGIENE EG. NO.	04-24	l <b>-</b> 95	11AM
		1. DECEDENT'S NAME (First, Middle, Last)  4. SOCIAL SECURITY NUMBER	S. SEX S. AGE	Kathry		chenbac	DER 24 HRS.	2. DATE OF E	Z Y	9	AR /	ME OF DEATH    O O M  E (State or Foreign
pino		212-32-9931 Se. FACILITY NAME (If not institution, give:	1 🗆 M 2 🗆 🗶	89 YR	MONTHS	DAYS HOUR	S MIN.	Oct	5 190		Maryli	
. 2, 3 should	TOR	Meridian Health C		pa Cree		nnapolis				- 12	e Aru	ndel
permit. Pages 1,	DIRECTOR	10a. STATE 10b. COUNT	Arundel	10c.	. CITY, TOWN O	R LOCATION napolis						INSIDE CITY LIMITS?
	AL	10e. STREET AND NUMBER 225 Gibson Road				101. ZIP CC	ODE			10g. CITIZEN	OF WHAT	COUNTRY?
-UUZU ling physician. the burial-transit	BY FUNER	11. MARITAL STATUS  1  Never Married 2  Married  3  Vidowed 4  Divorced	12. WAS DECEDENT EVER FORCES? 1 VES IF YES, GIVE WAR OR I	2 (10	1	WAS DECENDENT yes, specify Cu	iban, Mexicar	n, Puarto Ricar			RACE — Ai Black, White	States  merican Indian, la, etc.  White
Z I Z I S al or attend for use as	COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 12	CATION completed) College (1-4 or 5+)	(Give kind life. Do No	NT'S USUAL OC d of work done of OT use retired.)	luring most of wo	rking	16b. KIN		I HESS/INDUST		2
MAKYLAND retained by the hospital should be detached to notified at once.	ш	17. FATHER'S NAME (First, Middle, Last)  James E. Brown				18, M	_	ME (First, Middle trude S	e, Maiden Su	imame)		· · · · · · · · · · · · · · · · · · ·
be retained ge 5 should e notified	TO B	19a. INFORMANT'S NAME (Type/Print)  J. Richard Acher	back			(Street and Num	ber or Rural R	loute Number, C	City or Town,	State, Zip Coo		
ALTIMORE, eath. Page 6 may be funeral director, page xaminer must be		20s. METHOD OF DISPOSITION 1 A Purist 2 Cremetton 3 Rem 4 Donation 5 Other (Specify)	oval from Stata	b. PLACE AND DA	ATE OF DISPOS	TION (Name of		DATE	20c. LOCA	TION - City apolis	or Town, S	
0 = 0		21. SIGNATURE OF FUNERAL SERVICE U		/	22, (		RESS OF FAC	Johi	n M.	Taylor	Fun	eral Home
ed within 25 hours af ompletely filled in by al, cremation, or remo		23. PART i. Enter the diseases, pr shock, pr heart failure. IMMEDIATE CAUSE (Final disease pr condition resulting in death)	List DNI ona cause on a DUE TO (OR AS	each line.	An	the mode of	(1	l as cardiac	Dr reapiral	tory arreat	,	Approximata Interval Between Onset and Death
th certificate be exending physician a Hygiene prior to or other traum	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease pr injury that initiated events resulting in death) LAST	DUE TO (OR AS	1 1	,							
w requires that the death been signed by the atter pr. of Health and Mental shows any Injury, or	MEDICAL C	PART II. Other aignificant condition	s contributing to death	but not reault	ing in the un	derlying caus	e given in l		YES 2	ED?	COMI DF D	AUTOPSY FINDINGS ABLE PRIOR TO PLETION OF CAUSE EATH? YES 2 NO
as bept.		DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL	CONTRIBUTE TO	CAUSE	OF DEA	TH YES						
PHYSICIAN: The this certificate h with the State (	PHYSICIAN:	EXAMINER?  1 VES 2 NO  27. MANNER OF DEATH	HOSPITAL: 1   Inpatiant 2   ER/Out		TIME OF	ing Home 1 []	Residence	6 □ Other (%p				
DING PHYS After this of death with s marked	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)		INJURY M	28c. INJURY AT WORK? 1 YES 2		28d. DESCRIE	70			
TTEN TOR:	ETED	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJUR building, etc. (Spi	ecify)	irm, street, facti	ory, office		28f. LOCATIO City or To	N (Street end wn, Stete)	1 Number or F	Rural Route N	lumber,
	COMPLET	and .	CIAN: To the best of my known care in the bests of axamination								euse(s) end	manner as stated.
TO THE HOSPITAL (TO THE FUNERAL DE FILE WITHIN 72 PA IMPORTANT: IT IN	O BE	296. SIGN APONE AND TITLE OF CENTIFIE	241			29c. L	JCENSE NUM	78	2	DATE SI	GNED (Mont	h, Day, Year)
		36 HAMM AND ADDRESS OF PERSON WE	900 Beste	No 12	(Type, Print)	\$ 300	, 1	June	pr lis	mò	214	0
		31. DATE FILED (Month, Day, Year)  APR 25 1995	32. REGISTRAR'S PIG		4		,		/			
_			U									OHMH-16 Rev 1/89



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR EDWARD HUGH ATWELL APRIL 1995 04. 10:20 Α 4. SOCIAL SECURITY NUMBER 5 SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 214-32-7709 1 M 2 | F 63 NOV. 3, Washington, DC Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF OEATH 9c. COUNTY OF DEATH DIRECTOR 5901 31st. PL. HYATTSVILLE PRINCE GEORGE'S RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND PRINCE GEORGE'S HYATTSVILLE permit. 1X YES 2 NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5901 31st. PL. filled in by the funeral director, page 5 should be detached for use as the burial-transit 20782 United States retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 TES 2 X NO BY Specify: 3 X Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life, Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) Self-Employed 10 Automobile Mechanics 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Hugh Enfield Atwell BE Carolyn Louise Ladow 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Cheryl Percy 5901 31st Place, Hyattsville, Maryland hours after death. Page 6 may be 20782 Pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must 1 N Burlal 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Union Cemetery 4/7/95 Leesburg, Virginia examiner 21. SIGNATURE OF FUNERAL SEMPLE LICENSE 22. NAME AND ADDRESS OF FACILITY Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, MD 20722 medical 23. PART I. Enter the diseases or complications that Caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Interval Between 6 IMMEDIATE CAUSE (Final Onset and Death the disease or condition and completely fi o burial, cremation resulting in death) .. Carcinoma Liver -- (Hepatoma) event, 6 Months executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): Cirrhosis Liver traumatic CERTIFICATION 30 Years Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): signed by the attending physician. Health and Mental Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMEO? MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? any 1 YES ZY NO 1 YES 2 NO t, of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has b Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) . DR ATTENDING PHYSICIAN: The I DIRECTOR; After this certificate ha hours after death with the State Dv certificate I HOSPITAL: 1 YES 2 X NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4 ☐ Nursing Home 5 N Residence 6 ☐ Other (Specify) 0 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) marked, 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending M 1 YES 2 NO BY Investigation 2 Accident 3 Suicide 28a. PLACE OF INJURY — At home, farm, street, tactory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) .00 COMPLETED 6 Could not be 4 🔲 Homicide 28 determined 29a. CERTIFIER 1 💢 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. THE HOSPITAL C THE FUNERAL D filed within 72 ho (Check only one) = 2 MEDICAL EXAMINER: On the beals of exer ation and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. IMPORTANT: 296. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month. BE 2 2 12 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) K. Joseph Matthews, M.D., 6510 Kenilworth Avenue, Suite 1400, Riverdale 20737

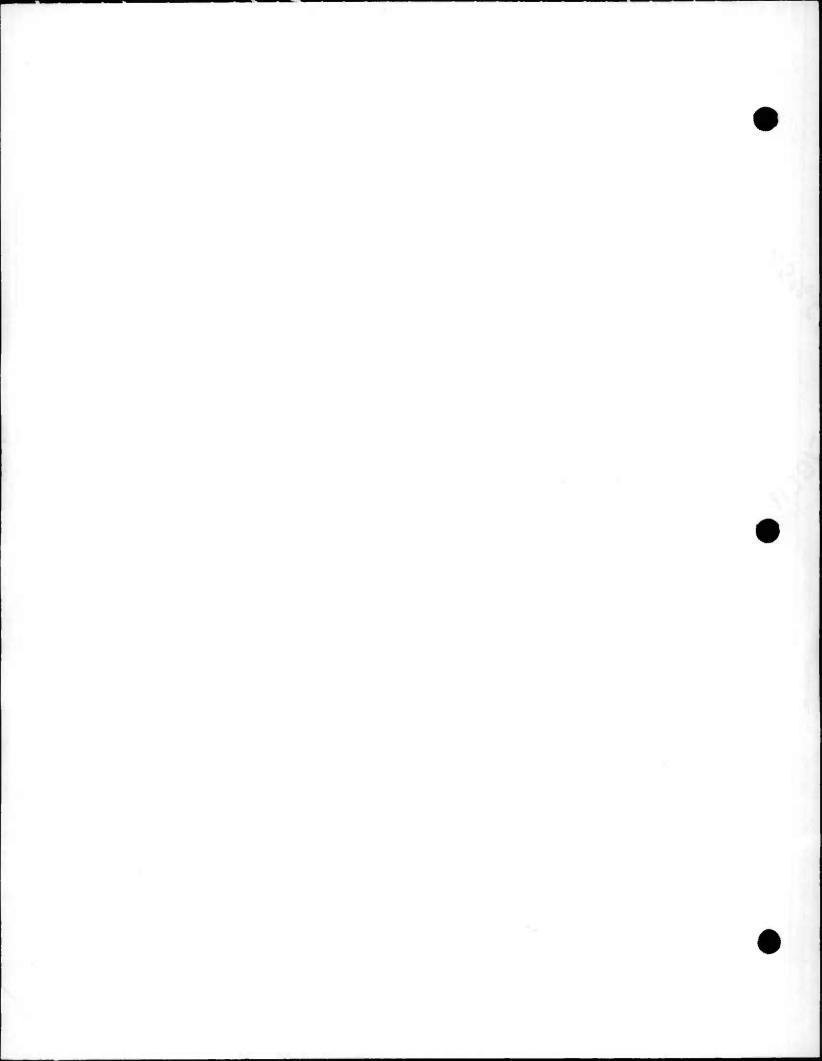
APR 10 1995

32 REGISTRAR'S SIGNATURE



IMPURIANE: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be neutified at once.

	FOR STATE REGISTRAR		STATE OF I	MARYLAND	DEPAI	RTMENT FICATE	OF 1	IEALTH	AND	MENT				1 0 4	
	1. DECEDENT'S NAME (First	Miriria ( ant)			ENTIF	ICATI	UF	DEA	ın		REG. N	0.	_		
												DAY	YEAR	3. TIME OF DEAT	Н
	4. SOCIAL SECURITY NUMBER		VIOL.			APPE:				Apr		1995		6:40 A	М
			1 M 2 X F	6. AGE (In yrs. le	- 227	IF UNDER	DAYS	HOURS	MIN.	7. DA1	TE DF BIRTH		8. BIRTH Countr	IPLACE (State or For ry)	reign
	220-32-3820			77	YRS.					Dec	19,	1917		WV	
~	90. FACILITY NAME (If not in	-	,					OR LOCAT	ION OF D	EATH			INTY OF D		
DIRECTOR	MEMORIAL H		Ш.			CON	BEK	LAND				AL	LEGA	NY	
<u>[</u> [	RESIDENCE OF DEC	10b. COUNT	v		10. 017	ry, town o									
E	MD	Alle	egany		1	dtow		IION.						10d. INSIDE CITY	
	10e, STREET AND NUMBER	71110	gury		1 01	u cow								1 🗌 YES 2 🔼	NO
₽ B		210						I. ZIP COD						WHAT COUNTRY?	
FUNERAL	Route 1 Bo	X 319	T					2155				US			
윤	1 Never Married 2	Married	12. WAS DECEDEN	YES 2	RMED NO	13.	WAS DEC	ENDENT I	OF HISPAI	NIC DRIC	GIN? (Specify Y	ea or No-	14. RACE Black	— Americen India k, White, etc.	ın,
B₹	3 Widowed 4 Divo		IF YES, GIVE V	WAR OR DATES			1 TYES	2 XND	Specif	y:	o Rican, etc.)		Speci	lfy:	
	15 DEC	EDENT'S EDU	CATION	40.0						_				white	
	(Specify on)	y highest grade	completed)	(0	ive kind of	Work done is retired.)	during mo	ost of worki	ng	-   1	6b. KIND OF B	JSINESS/IN	DUSTRY		
12	Elementary/Secondary (0	1-12)	College (1-4 or 5	*/	omema						O 1	T			
COMPLETED	17. FATHER'S NAME (First, M	Veletta di anti		n	anema	iker		200			Own 1	_			
											t, Middle, Maide	n Surname)			
BE	Taylor V		er		_						apes)				
2	19a. INFORMANT'S NAME (7										imber, City or To				
	Roena E. S			[7.	12 L€	eiper	St	reet	Cur	nber	land,	MD 2	21502		
	29e METHOD OF DISPOSITE 1-(2) Burial 2 □ Cremetic	ION on 3 ☐ Rame	oval from State	20b. PLACE cemetery, cre	AND DATE	OF DISPOS	ITION (N	ime of		1		OCATION -			
	4 Donation 8 Dother	(Specify)		_ Davi	s Men	noria	1 Ce	emete	ery	04	/15 Ci	mber.	land,	, MD	
	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE	,	1	22.	NAME A	ND ADDRE	SS OF FA	CILITY	7				
	► Uppe	01	Dras	21/	/_						1 Home	!			
	23. PART / Enter the d		CICCO	70111	1		unioe	erlar	ia, i	עני	21502				
	shock, or h	eart failure.	List Dnly ons ceu	ise on each line	98th. DO 1	not enter	the mo	de of dy	ing, suc	h ss ce	erdiec or ree	olratory er	rest,	Approxima Interval Ba	
	IMMEDIATE CAUSE (Fir disease or condition	el												Onset and	
	resulting in death)	<b>→</b>	•	stitial			a of	the	Bra	in				Two Y	ears
			DUE TO	(OR AS A CONSE	OUENCE O	NF):									
Z	Sequentially list conditi	000	b												
CERTIFICATION	if any, leading to imme-	diate	DUE TO	(OR AS A CONSE	OUENCE O	F):									
2	cause. Enter UNDERLY! CAUSE (Disease or inju		c												
불	that initiated events resulting in death) LAS		DUE TO	(OR AS A CONSE	DUENCE D	F):									
E	resulting in destill LAS	' (	d												
0	PART II. Other significe	nt condition	s contributing to	death but not i	regulting	In the un	derivin	COURS (	nhen in	Dort I	24a. WAS A	LAITMONOV	1 000	WERE AUTOPSY FIN	101100
₹	Sjogren				ocaning		dellynn	a conse i	Aradii iii	rart I.		RMED?	246.	AMILABLE PRIOR T	O
ā	_ Jogren	o oyn	<u>arome</u>							_	1 🗆 YES	2 PND		DF DEATH?	AUSE
Σ								- 4						1 TES 2 N	0
Ä	DID TOBACCO U		RIBUTE TO CA					UNC	ERTAIN	4 <u></u>					
S	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSFITAL:	26. PLAC	E OF DEA	TH (Check )									
ıs.	1 TES 2 NO		1 Inpatient 2	ER/Outpatient 3	□ DOA			e 5 🗆 Re	sidence	8 🗆 Oti	her (Specify)				
PHYSICIAN: MEDICA	27, MANNER OF DEATH		28a. DATE OF (Month, D		28b. TIN	IE OF	28c. INJ	URY AT		28d. D	EŞCRISE HOW	INJURY OC	CURED	-	
BY		Pending Investigation		-,,	""	M		/ES 2	ND						
	n D Sulate	Could not be	28e. PLACE O	F INJURY — At he etc. (Specify)	me, tarm,	street, fact	ory, offic	•		281. LC	CATION (Street	and Number	or Rural R	loute Number,	
		determined	Danony,	енс. (эресну)					l	Cit	ty or Town, State	)			
COMPLETED	29a. CERTIFIER 1 CERT	IFYING PHYSI	CIAN: To the beat of	my knowledge de	oth corre	ad as the re	me d-s	and of-		do st		- 1			
N N			R: On the basis of e												200
8				- Indiana	vengedo	an miny o	print011, 0	watti occui	ou at the	unie, de	nw and place, e	na aue to th	re Câuse(e)	and menner ae st	med.
BE	296. SIGNATURE AND TITLE	OF CENTIFIER						29c. LICI	ENSE NUN	ISER		29d. DAT	ESIGNED	(Month, Day, Year)	
6	10/10m							D 1	4865			1	4 m	13.19	995
- 1	30. RAME AND ADDRESS OF												V	1	
	Dr. R. Bar	rera	Memorial	Hospit	al Me	edica	1 B	ldg.	Cum	ber]	land. N	D 2	1502		
	31. DATE FILED (Month, Dey,	Year)	22. REGISTRA	R'S SIGNATORE	.H										
- 1	APR 1	1995	The way	TOPP TOPP	A CONTRACTOR										



FOR

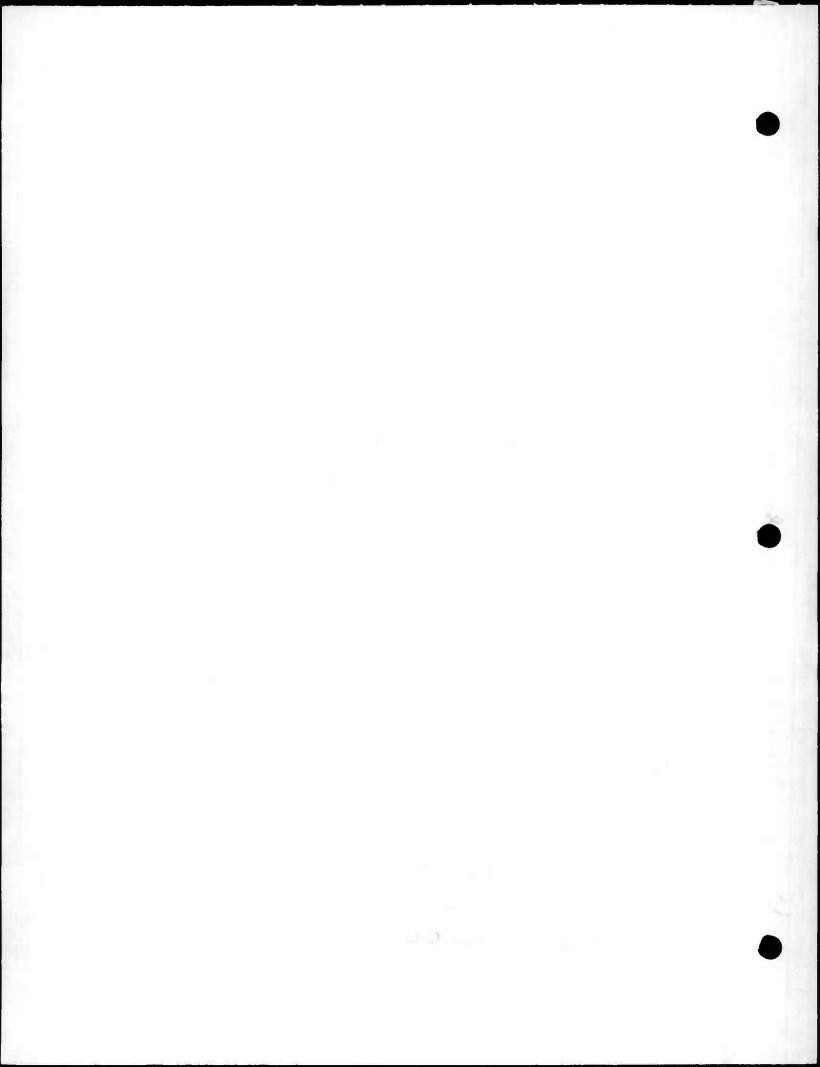
## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - REGISTRAR		CERTIF	CATE C	F DEATH	REG. NO		
-	1. DECEDENT'S NAME (First, Middle, Last) WILLIAM	EARL BRO	OWN			2. DATE OF DEATH		3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 215 34 8349		(In yrs. last birthday) 7 YRS.	IF UNDER 1 YES		7. DATE OF BIRTH	8	BIRTHPLACE (State or Foreign
	Se. FACILITY NAME (If not institution, give	atreet and number)		9b. CITY, TOV	VN OR LOCATION OF O			Y OF DEATH
TOR	PHYSICIANS MEI	MORIAL HOSE	PITAL	LaPI	LATA		CHA	ARLES
DIRECTOR	Maryland Calve		100	r, town on Lo Lusby	CATION			10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 11850 H.G. Trueman Ro	ad			101. ZIP CODE 20657			n of what country?
B	11. MARITAL STATUS  1 V Never Married 2 Married  3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 TYPES IF YES, GIVE WAR OR D	2 (ANO	If yes	DECENDENT OF HISPAN , specify Cuban, Maxica YES 2 NO Specifi		or No 14	I. RACE — American Indian, Black, White, etc. Specify: WILLE
ED :	15. DECEDENT'S EDU (Specify only highest grade	JCATION a completed)	16a. DECEDENT'S (Give kind of v	rock done during	ATION I most of working	18b, KIND OF BU	SINESS/INDUS	STRY
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	Truck Dr	e retired.)	55.0	Tra	ensporta	ation
S.	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	-	
BE	John William Brown				Ruth Pa			
10	Virginia Lusby			as #10	eet and Number or Rural i	Route Number, City or Tow	rn, State, Zip Co	ode)
	20a. METHOD OF DISPOSITION 1X Burlel 2 Cremetion 3 Ren 4 Donation 6 Other (Specify)	ioval from State 201	b. PLACE AND DATE OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR OF THE COLOR	F DISPOSITION	il 26, 1995		CATION — CIT	y or Town, Stata Yland
	21. SIGNATURE OF FUNCHAL SERVICE LI	CENSEE		22. NAMI 4405 I	e and address of fa Broomes Is. I	d. Port Rep.	Funeral blic Ma	Horne Iryland 20676
CERTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	bDUE TO (OR AS /	A CONSEQUENCE OF	): ):		JUNIC V		
		d						
MEDICAL	PART II. Other algolificant condition	is contributing to death b	but not resulting i	n the underl	ying cause given in	Part i. 24a. WAS AN PERFOR	RMED?	24b. WERE AUTOPSY FIND AWAILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO
	DID TOBACCO USE CONT	RIBUTE TO CAUSE C	OF DEATH YE	S   NO	☐ UNCERTAIN	V 🗆		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 X X ES 2 □ NO	HOSPITAL: 1   Inpatient 2   XER/Outs	26. PLACE OF DEAT	OTHER:				
H	27. MANNER OF DEATH	28s. DATE OF INJURY	28b. TIME	OF 28c.	INJURY AT	8 Other (Specify) 28d. OESCRIBE HOW I	NJURY OCCUP	RED
BY	1 Naturel 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJI	M 1	WORK?  YES 2 NO			
<b>a</b>	3 Suicide 6 Could not be 4 Homicide detarmined	28e. PLACE OF INJURY building, atc. (Spec	Y — At home, farm, s loffy)	treet, factory, c	offica	28t. LOCATION (Street City or Town, State)	and Number or	Rural Route Number,
COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYS	ICIAN: To the best of my know ER: On the bests of examination	viedge, death occurre	d at the time, o	data and place, and dua n, death occured at the	to the cause(a) and mai	nner as stated.	ause(s) and manner as state
TO BE C	BIGHATUME AND TITLE OF CENTIFIE	" Delec	Atu		O.C.M.I	HER	29d. DATE S	RIL 25, 199
	MARIO F. GIOL		111 Peni	ACT IN SEC.	eet, Bal	timore, N	Maryla	and 21201
	31. DATE FILED (MOREN, Day: Year)  APR 2.6 1995	32. REGISTRAR'S SIGN	x-Rardall					

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

DHMH-16 Rev 1/89



1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

					CALE OF			REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)		~				2. DATE OF			33	3. TIME OF DEATN
	James	<	BI	stle	0		AMONTH	DAY	100	YEAR	10:084 "
- 1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las		IF UNDER 1 YEAR	IF UNDER 24 HRS.	T. DATE OF	201	177	7	
					MONTHS DAYS	NOURS MIN.	(Month, D	lay, Year)		8. BIRTNP Country)	LACE (State or Foreign
- 1	218-36-3430	1 XM 2 - F	54	YRS.		3,63,65	Apr.	23,1	940	Mar	yland
- 1	9s. FACILITY NAME (If not institution, give :	street and number)			9b. CITY, TOWN (	OR LOCATION OF I	DEATN		9c. COUN	TY OF DEA	ATN
1 5	Prince George's (	General H	lospital		Cheve	r1v			Dadas	o Co	eorge's
ΙĶ	RESIDENCE OF DECEDENT		COPICAL		Offeve	гту			LITHC	e Ge	orge s
DIRECTOR	10a. STATE 10b. COUNT	Υ		10c. CITY	TOWN OR LOCAT	TION					10d. INSIDE CITY
15	Maryland Cal	vert		Ch	o an a alea	Pageh				- 1	LIMITS?
	10e. STREET AND NUMBER	VELL		Cite	esapeake						1 YES 2 NO
%	Post No. 1. In the reaction				101	I. ZIP CODE			10g. CITIZ	EN OF WH	HAT COUNTRY?
FUNERAL	6630 Old Baysic	le Road				20732			U	JSA	
5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	MED	13. WAS DEC	ENDENT OF NISPA	ANIC ORIGIN? (	Specify Yes	or No-	14. RACE -	- American Indien,
	1 Never Merried 2 X Merried		MAR OR DATES	10		ecity Cuben, Mexic		en, etc.)		Black,	white, etc. Black
8	3 Widowed 4 Divorced					- 22 110 0,000	,.			Specify.	DIACK
ETED	15. DECEDENT'S EDU		16a. DE	CEDENT'S (	SUAL OCCUPATION	ON	16h KI	ND OF BUSI	INESS/INDI	ISTRY	
15	(Specify only highest grade		(Gi	Do NOT use	ork done during mo	asl of working	100110	0, 000.	III COO III COO	301111	
ᅵ군	Elementary/Secondary (0-12)	College (1-4 or 5	+)			0661		_			
COMPL			Loge	Enic	rcement	Office		m of		arde	n
5 8	17. FATHER'S NAME (First, Middle, Last)	_				18. MOTNER'S N	AME (First, Mide	die, Maiden S	Sumame)		
삤	James	E	Butler	•		Mary	H		V	lalla	ce
B B	19a. INFORMANT'S NAME (Type/Print)		198	. MAILING	ADDRESS (Street e	and Number or Rura	Aoute Number,	City or Town,	State, Zip	Code)	
일	Kirk Butler					r. Upp					2
2	20e. METNOD OF DISPOSITION							7			
te l	1 XBuriel 2 Cremetion 3 Rem	novel from State	cemetery, crei	matory or oth	F DISPOSITION (Na er place)	ame of	DATE	]	ATION — C		1000
E	4 Donation 5 Other (Specify)		Bethel	Way	of the	CrossCer	n.4/26/	<u>/195 1</u>	Hunti	ngto	wn, MD
를	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE			22. NAME A	ND ADDRESS OF F	ACILITY Set	vell I	Funer	al H	ome
ž i	1 than see	CX.	/	20	1451 D	ares Rea					rick, MD
8	spences	1. 110	mer	1							TICK, III
	23. PART I. Enter the diseases, or shock, or heert failure.	Complications the	at coused the de	ath. Do no	ot enter the mo	de of dying, su	ch aa cerdled	or reapire	atory arre	eat,	Approximata
Ē											Onset and Death
Ě	disease or condition	Diah.Ti	1. A.D		and.	31.1.	0	4.4.	. Arra	. 1	1/ .10
끝	resulting in death)					A A 1 A 4 A I A A A					1/ 1///
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EVE.		DUE TO	(OII) A CONSEC	DUENCE OF	unu	Waler	TIL IL	de	Slac	ente	413.
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aumatic ever	Sequentially list conditions, if any, leading to immediate	b	(OR AS A CONSEC			wyeus	The l	de	Slac	eulo	413.
r traumatic ever	Sequentially list conditions,	b	(OR AS A CONSEC	OUENCE OF)	:	ware	The le	de	Slac	ento	413.
other traumatic ever	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	b		OUENCE OF)	:	wan	ne i	de	glac	e_	413.
or other traumatic event, the medical examiner must be notified at once.  ERTIFICATION TO BE COM	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	b	(OR AS A CONSEC	OUENCE OF)	:	Wallia	ne i	dr	Slac	e_	413.
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DESCR  28t. LOCATIC City or 3	pecily)  IBE NOW IN.  ON (Street en own, State)	JURY OCCU	24b. WAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA	WERE AUTOPSY FINDINGS WAIL ABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  U YES 2 NO  uite Number, and menner sa stated.

TO THE HOSPIPL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO BE COMPLETED BY FUNERAL DIRECTOR BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

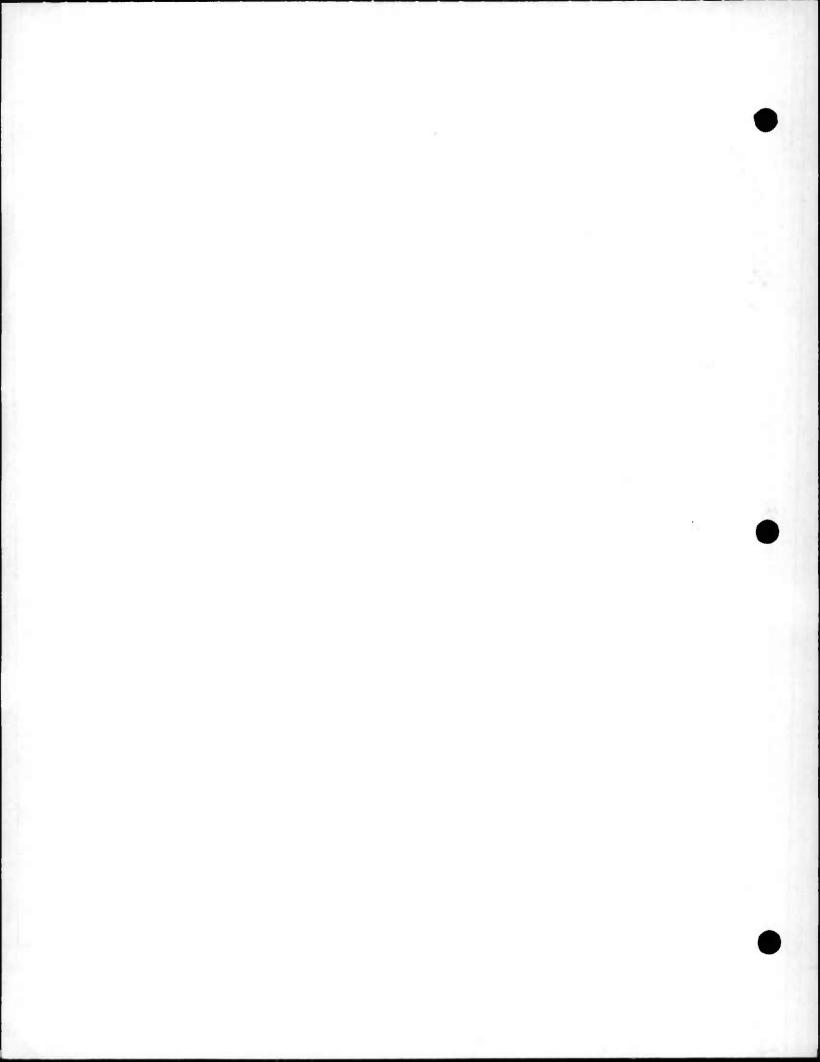
31. DATE FILED (Month, Day, Year)

APR 21

1995

32, REGISTRAR'S SIGNATURE

1 - STATE REGISTRAR	STATE OF MA	ARYLAND /	DEPART	MENT	OF H	EALTH AND I					
1. DECEDENT'S NAME (First, Middle, Last)			Enter	CAIL	OF	DEATH	2. DATE OF DE	G. NO.			- 7000 00 00 00 100
Matthew Josep	1						April	17, DAY	199	5 S	3. TIME OF DEATH 7:05 p M
577-05-8182	5. SEX 6	8. AGE (In yrs. les		IF UNDER 1	YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIF (Month, Day, Oct 18	110 191	13	8. BIRTHP Country) New	LACE (State or Foreign Jersey
9a. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY, T	O NWO	R LOCATION OF DE				TY OF DE	
3817 26th Street				Che	esaj	oeake Be	ach		Cal	vert	
10a. STATE 10b. COUNTY	Calvert		10c. CITY,	TOWN OR		oeake Be	ach			ŀ	10d. INSIDE CITY LIMITS?
10e. STREET AND NUMBER					-	ZIP CODE	40.1.	10	∩a CITIZ		1 X YES 2 NO
3817 26th Street						20	732		US		TAI COONTREE
11, MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT & FORCES? 1	YES 2 X	NO	13. W	AS DECE	ENDENT OF HISPAN	IIC ORIGIN? (Spe	cify Yea or	No-	14. RACE - Black.	- American Indian, White, stc.
3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE WAR	OR DATES		1 [	YES	2X NO Specify		,		Specify	
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9	College (1-4 or 5+)		eet m				con	struc	ctio	n	
17. FATHER'S NAME (First, Middle, Last)		D- 1200				18. MOTHER'S NA		Maiden Sun	name)		
Joseph  19a. INFORMANT'S NAME (Type/Print)		Burg			-: III.	Stephan					ohi
Irene E. Moore						ane, Lau				Code)	
20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remo	oval from State	20b. PLACE A	AND DATE OF	DISPOSITI	ION (Nar	ne of	DATE	20c. LOCAT	ION — C		
4 Donation 6 Other (Specify)  21. SIGNATURE OF FUNERAL SERVICE LIC	FNSEE	Metro	polit	_	_	atory 4		Alex	xand	lria,	VA
· William R ?	k.			Rai	ıscl	n Funera	l Home,			_	s, MD
23. PART I. Enter the diseases, of shock, or heert failure.  IMMEDIATE CAUSE (Final disease or condition resulting in deeth)	List only one cause	on eech line.	).								Approximete Interval Between Onset and Death
resulting in destrij			6	77-	0	7- 10	RO5-	TAT	p form		
Secretary that are duty			OUENCE OF)		0	7-12	ROST	rAT	E	-	
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H any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST  PART II. Other significent condition  DID TOBACCO USE CONTINE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	DUE TO (OI  c. DUE TO (OI  d. B. Contributing to de  RIBUTE TO CAUS  HOSPITAL: 1   Inpatient 2   Ei  26a. DATE OF IN. (Month, Day,  26a. PLACE OF IP building, atc.	R AS A CONSECT  R AS A CONSECT  Beath but not re  SE OF DEA!  26. PLACE  R/Outpetient 3  JURY  Year)  NJURY — Al hor  C (Specify)  r knowledge, das  nination and/or in	DUENCE OF):  DUENCE OF):  DUENCE OF):  TH YES  E OF DEATH  DOA   266. TIME.  INJUI  me, tarm, str	the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the un	orlying y one) g Home Sc. InJuly WOR 1   You	UNCERTAIN  5 Presidence  RY AT  IK?  ES 2 NO  and place, and due  ath occured at the	Part I. 24a. V P P 1	WAS AN AUTERFORMED  YES 2  HOW INJUI  (Street and fr., State)  Ind manner  Inca, and du	RY OCCU	24b. A A C C C C C C C C C C C C C C C C C	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  YES 2 NO  Ute Number, and manner on stated.
H any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST  PART II. Other significent condition  DID TOBACCO USE CONTINE  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1	DUE TO (OI  C. DUE TO (OI  d. BE CONTributing to de  BE CONTRIBUTE TO CAUS  HOSPITAL:  1 Inpatient 2 Ele  28a. DATE OF IN.  (Month, Dey.  28a. PLACE OF IP  building, atc.  CIAN: To the best of my  R: On the best of axam	R AS A CONSECT  R AS A CONSECT  Beath but not re  SE OF DEA!  26. PLACE  R/Outpetient 3  JURY  Year)  NJURY — Al hor  C (Specify)  r knowledge, das  nination and/or in	DUENCE OF):  DUENCE OF):  DUENCE OF):  TH YES  E OF DEATH  DOA   266. TIME.  INJUI  me, tarm, str	the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the under the un	orlying y one) g Home Sc. InJuly WOR 1   You	UNCERTAIN  5 Presidence  FRY AT  IK?  ES 2 NO  and placa, and dua  ath occured at the	Part I. 24a. V P P 1	WAS AN AUTERFORMED  Typ)  HOW INJUI  (Street and f. State)  and manner aca, and du  29:	RY OCCU	24b. VA A C C C C C C C C C C C C C C C C C	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO DIMPLETION OF CAUSE OF DEATH?  YES 2 NO  When Number,



YEAR

New

10g. CITIZEN OF WHAT COUNTRY?

U.S.A.

Specify:

14. RACE — American Indian, Black, White, etc.

Caucasian

21012

MD

Approximata

Intervsi Between

**Onset and Death** 

6

1995

9c. COUNTY OF DEATH

Anne

1907

3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign

6

York

Arundel

10d. INSIDE CITY

1 TES 2 NO

A

REG. NO.

2. DATE OF DEATH

В. Winnifred Bode April 26. 7. DATE OF BIRTH (Month, Day, Year)
JAN 10, 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 24 HRS. 1 M 2 X F MONTHS DAYS HOURS 471-52-1958 88 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN DIRECTOR Country Home Harwood 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Anne Arundel permit. Harwood FUNERAL 10e STREET AND NUMBER 10f. ZIP CODE the funeral director, page 5 should be detached for use as the burial-transit 4187 Solomons Island Road 20776 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
It yes, specify Cuben, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify: BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married BY 3 Wildowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 8+) 12+ Homemaker Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at BE Frederick Byers Lucia Edwards 19a. INFORMANT'S NAME (Type/Print) 19b. MAILIND ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Marcia Lopata 1455 Point Way Arnold, Maryland 9 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State must 1 Buriel 2 Commation 3 Removal from State
4 Donation 5 Other (Specify) cemetery, crematory or other place) 27-1995 matory 4-27-1 Baltimore, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSE Barranco & Sons Funeral Home 495 Ritchie Hwy Severna medical ART I. Ener the diseases, or complete ions that caused the deshock, or heart failure. List only one cause on each line. callions that caused the death. Do not antar the mode of dying, such as cardisc or respiratory street, filled in by 6 IMMEDIATE DAUSE (Finsi cremation, event, the disease or condition resulting in death) N emars been signed by the attending physician and completely at, of Health and Mental Hygiene prior to burial, crematic DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentisity list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, lasding to immediate death certificate be cause. Enter UNDERLYING CAUSE (Disesse or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initisted eventa resulting in death) LAST 6 PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY MEDICAL PERFORMED? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES INO UNCERTAIN 🔲 has by Dept. OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h HOSPITAL: OTHER: 1 TES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATN 28a. DATE OF INJURY (Month, Day, Year) 28c, INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE NOW INJURY OCCURED marked, this c 1 Natural 2 Accident 5 Pending M 1 YES 2 NO BY After 1 28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Suicide DIRECTOR: A hours after of S ETED. 8 Could not be 4 Homicide 50 29a. CERTIFIER
(Check only one)

A MEDICAL EVANIANTS, Or the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. COMPL TO THE HOSPITAL (
TO THE FUNERAL D
DE filed within 72 h
IMPORTANT: If in 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 9c. LICENSE NUMBER BE 3

COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAP'S SIGNATURE

MD

2001

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

FOR STATE REGISTRAR

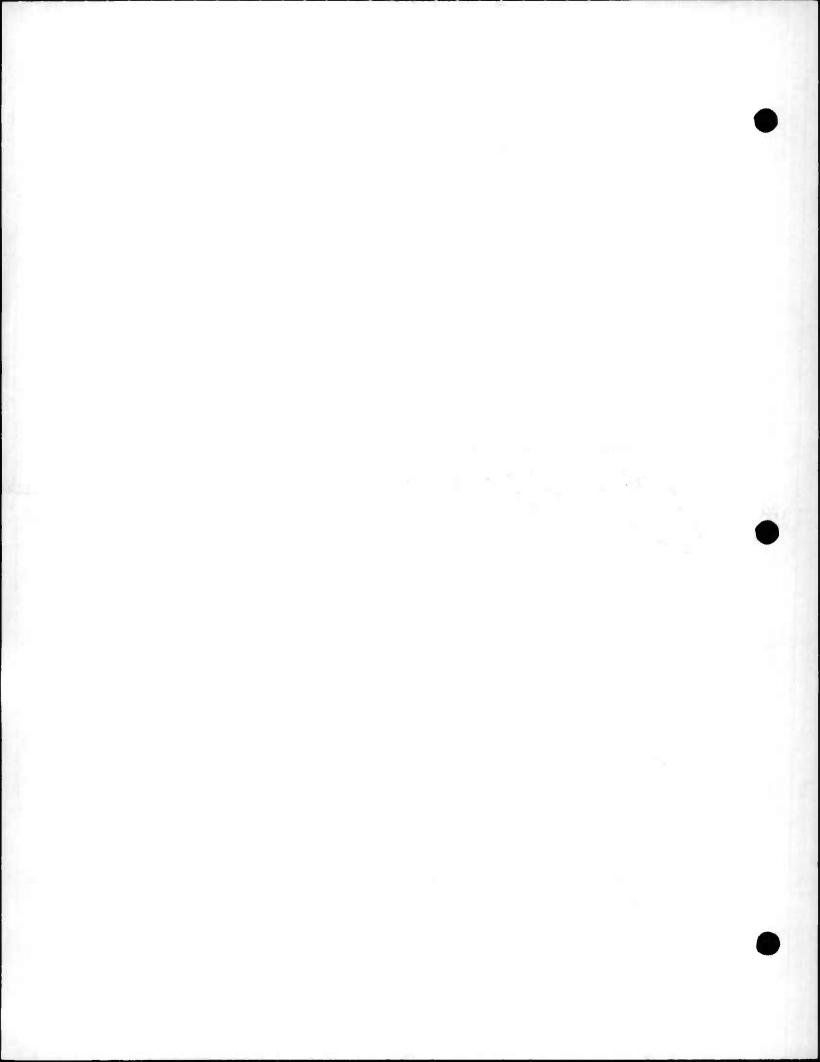
2

30. NAME AND ADDRESS OF PERSON WHO

1995

1. DECEDENT'S NAME (First, Middle, Last)

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) 9 DHMH-18 Rev 1/89



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH VEAR ishap Birdell B.Bishep April 1095 0605 4. SOCIAL SECURITY NUMBER 7. Date of Birth (Month, Day, Year)

Peb-26, 1935 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 F DAYS HOURS 228-42-6752 60 Black MARYIAN Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH PENINSULA REGIONAL MEDICAL CENTER DIRECTOR SALISBURY WICOMICO RESIDENCE OF DECEDENT 10a. STATE MD. 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Virginia ccomeck WORCESTE, POCOMOKE CITY 1 YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10f, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? use as the burial-transit 702 9th St. Pocomoke City, 21851 United Staets hours after death. Page 6 may be retained by the hospital or attending physician, 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yea, specify Cuben, Maxican, Puerto Rican, stc.) 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 YES TO NO Black BY Specify 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most clife. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY detached for Elementary/Secondary (0-12) College (1-4 or 5+) Weigh Master 7grade Perdue Farms 17. FATHER'S NAME (First, Middle, Leat) 16. MOTHER'S NAME (First, Middle, Maiden Surname) funeral director, page 5 should be H. Bishop Charles Lena Marshall Bishop BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Rose L. Bishop 702 9th.St.Pocomoke City, Md. 21851 9 20a. METHOD OF DISPOSITION

1 № Burlal 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must Warotown Cem Pecemoke City, Md. ☐ Donation 5/☐ Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Savage Funeral Rose 46 3812 Danis Church, Va.23415 removal. New medicai AS. PART I. Enter the diseases, or complications that caused the death of not enter the mode of dying, such as cerdiec or respiratory arrest, filled in by Approximete ehock, or heert fellure. List only one ceuse on each ligs 0 interval Between IMMEDIATE CAUSE (Finel Onset and Death cremation, the disease or condition UNG completely Cancer event, resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 OUE TO (OR AS A CONSEQUENCE OF): and com burial, Jailin ina ton traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene pri 2 if any, leeding to immediate cause. Enter UNDERLYING death certificate be CAUSE (Disesse or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events attending resulting in death) LAST 6 d by the atten Injury. PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. requires that the MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? any signed Health a 1 TYES 2 N NO Shows 1 YES 2 NO t. of PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ has by Dept. OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF OEATH (Check only one) Item certificate I HOSPITAL: OTHER: 1 TES 2 NO 1 Inputient 2 K ER/Outputlent 3 I DOA 4 - Nursing Home 5 - Residence 8 - Other (Specify) 6 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c, INJURY AT 28d. DESCRIBE HOW INJURY OCCURED this c marked. Natural 5 Pending 1 YES 2 NO BY After 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, term, street, factory, office building, stc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 40 6 8 Could not be DIRECTOR: / 4 Homicide 28 determined Ш item 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(s) end manner as stated. COMPL HOSPITAL C FUNERAL D WITHIN 72 h TO THE FUNERAL ID FINE FINE TO THE FUNERAL ID BE filed within 72 h 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, date and placs, and due to the cause(s) and menner es stated. 296. MIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNEO (Month, Day, Year) 29c. LICENSE NUMBER BE 2 PLETEO CAUSE OF DEATH (ITEM 27) (Type, Print) 560 31. DATE FILED 2 i transporte

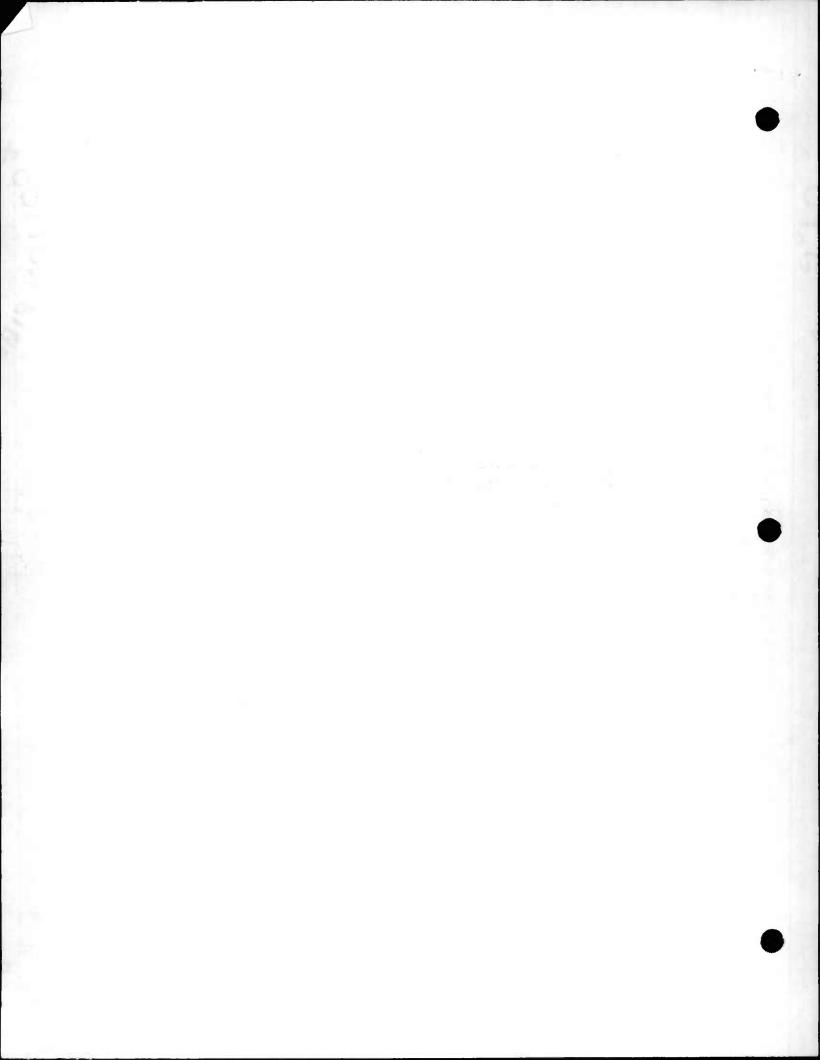
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DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

1 - FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First	Middle Leath								rica. No.			
			RLY	J 0	DAI	12	001	121	1		DATE OF OEATH	Y	YEAR	3. TIME OF OEATH
		4. SOCIAL SECURITY NUMBER	1	5. SEX	6. AGE (in yrs. i	C I	IF UNDER 11		IF UNDER 24 HR	-	420	2 9	5	342 M
		218-32-774		1   M 2   F	. ,				HOURS MIN	. (	ATE OF BIRTH Worth, Day, Year)		Country	
pinous		9a. FACILITY NAME (If not in			5	/	95 CITY T	WW 00	LOCATION OF	J.F	AN.23,1			NSYLVANIA
S S	Œ	CARROLL CO			носр	TUNT			NSTE				TY OF DE	
1, 2,	СТОВ	RESIDENCE OF DEC		ODNORAL	HOSE	TIAL	WES	TPIL	142151	<u> </u>		CA	RRO	ПП
Pages	DIRE	10a. STATE	10b. COUNTY	Y		10c. CIT	Y, TOWH OR	LOCATIO	ON					10d. INSIDE CITY LIMITS?
<u>اخ</u>		MARYLAND		CARROLL		WI	ESTMI	NST	ER					1 YES 2 NO
permit.	₹ I	100. STREET AND NUMBER						10f. Z	IP CODE					HAT COUNTRY?
eruing proyacian. as the burial-transit	FUNERAL	130 SMITH	AVE.						211	57		U	SA.	
nysici urial-t	F	11. MARITAL STATUS  1 Never Married 2	Marriad	12. WAS DECEDENT FORCES? 1	EVER IN U.S. /	NO	13. WA	S DECEN	IDENT OF HIS	PANIC Of	RIGIN? (Specify Yea arto Rican, etc.)	or No-	14. RACE Black	- American Indian, White, etc.
D d	BY	3 Widowed 4 Divo		IF YES, GIVE W	AR OR DATES				NO Sp				Specif	
e as	8	15. OEC	EDENT'S EDU	CATION	16a. C	DECEDENT'S	USUAL OCC	JPATION		T	16b. KIND OF BUS	INESS/IND	ICTOV	MUTIE
or use		(Specify online Elementary/Secondary (0	y highest grade	completed) College (1-4 or 5 +		(Give kind of vite. Do NOT us	vork done dun	ing most	of working		100. 1010 01 000	MESS/MD	751H1	14
bed fi	릴	12	,	Oollege (1-4 of 5 7)			SEC	RET	ARY		EDUCA'	TION		
detach once.	COMPL	17. FATHER'S NAME (First, M	iddle, Last)					1	18. MOTHER'S	NAME (F	irst, Middle, Malden S	Surname)		
# 6 E	l w		JAM	IES	RITTE	R			MA	RGA	RET W	IKE		
5 should be detached for notified at once.	0 8	19a. INFORMANT'S NAME (7	,, ,		1	19b. MAJLING	ADDRESS (S	treet and	Number or Ru	ral Floute	Number, City or Town	, State, Zip	Code)	
age 5		BRYAN J.	BOSLE	CY		210 M	IUD C	OLL	EGE F	RD.,	LITTLES	STOW	N, P	A. 17340
funeral director, page		20a. METHOD OF DISPOSITI		oval Irom State	20b. PLACI	EANDDATE	F OISPOSITI	ON (Name	e of		DATE 20c. LOC	CATION — C	ity or Tov	wn, State
lirector, p	- 8	4 ☐ Donation 8 ☐ Other	(Specify)		LEIS	STER	S CE	MET	ERY 4	/29	/95 WES	STMI	NST	ER, MD.
tuneral dir funeral dir f. examiner		21. SIGNATURE OF FUNERA	L SERVICE LIC	HSEE /	_//	6	22. NA	ME AND	ADDRESS OF	FACILITY	FLETCHI	ER F	UNEI	RAL HOME
0 70		21. SIGNATURE OF FUNERAL SERVICE LICENSEE  22. NAME AND ADDRESS OF FACILITY FLETCHER FUNERAL HOME 254 E.MAIN ST., WESTMINSTER, MD. 21157										,MD.21157		
d in by the or removal.		23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, ahock, or heart failure. List only one cause on each line.												
POE		ahock, or he IMMEDIATE CAUSE (Fin	eart iallure.	List only the ceus	e on aach iir	ne.								interval Batween Onset and Death
		disease or condition	<b>→</b>	CAR	DIOG	ENI	0	91	1 mel	1				Unol 10 G
completely ial, cremat event, t		resulting in death)	•	OUE TO	OR AS A CONS	EOUENCE OF	7):	1		-				4001
n and con to burial, imatic e	z			ACLIT	EI	NF	ER	ne	RI	7 A	LLD	141	MAR	PH- LERHR
ending physician and control Hygiene prior to buria	CERTIFICATION	Sequentielly list conditi if any, leading to immed	diate	DUE TO (	OR AS A CONS	EQUENCE OF						10	71-117	4 A O ELL
attending physician mal Hygiene prior t	2	cause. Enter UNDERLYi CAUSE (Disease or Inju		с	11-16		NI	- 6	1RC	11	DU			
oth die	ᄩ	that initiated events resulting in death) LAS	T	DUE TO (	OR'AS A CONSI	EQUENCE OF	): '		•	`	•			
attender Hall H	崽			d								-		
in signed by the attending physical Health and Mental Hygiene tows any Injury, or other		PART ii. Other aignifice	nt condition	a contributing to	leeth but not	reaulting i	n the unde	rlying c	ause given	in Pert	i. 24a. WAS AN A			WERE AUTOPSY FINDINGS
th an	MEDICAL	REN	JAL	EF	1114	RE					PERFORI	1		AVAILABLE PRIOR TO COMPLETION OF CAUSE
signed Health a	NE I										10.63 /	110		DF DEATH?  1 YES 2 NO
certificate has been the State Dept. of 1, or item 23 sho		DID TOBACCO U	SE CONTI	RIBUTE TO CAL	JSE OF DE	ATH YE	S 🗆 NO		UNCERTA	NIN X	il			
te has	SIA	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL		26. PL/	ACE OF DEAT		one)		_/		***************************************		
ntificate has been been or item 23 st	HYSICIAN:	1 YES NO		HOSPITAL:	ER/Outpatient	3 DOA	OTHER:	Home	5 🗆 Residence	. 8 🗆 6	Other (Specify)			
is cer	E	27. MANNER OF DEATH		28a. DATE OF I		28b. TIMI		c. INJUR	Y AT	28d.	DESCRIBE HOW IN	JURY OCC	JRED	
3. After this control of death with is marked,	B		Pending Investigation				M	YES						
R. Af			Could not be	28e. PLACE OF building, a	INJURY - At htc. (Specify)	nome, Jerm, s	treet, factory	offica		281.	LOCATION (Street ar City or Town, State)	nd Number o	r Rural Ro	oute Number,
DIRECTOR: After this hours after death with Item 28 is marked	ETE	4   Homicide	determined								1888			
AL DIRECT TO hours	립			CIAN: To Ihe best of r										
THE FUNERAL filed within 72 h	COMPL													and manner as stated.
HE FE	w I	29b. SIGNATURE AND TITLE	OF CERTIFIEF	7				2	9c. LICENSE N	UMBER		29d. DATE	SIGNED (	(Month, Day, Yeer)
TO THE FUNERA De filed within 7 IMPORTANT: 1	8 0	Hal002	A	Lupm	)	(B)	n		02	Sn	52	14	12	695
	유	30. NAME AND ADDRESS OF	PERSON WH	COMPLETED CAUSE	OF DEATH (IT		Print)			- 1		3	111	711
		HAFFEZ	P	SYE	) 5	20 0	1099	5 RI	Dand	5	Dr. n	LIDIT	09	Millamall
		31. DATE FILED (Month, Day,	fear) /1.	32. REGISTRAR	'S SIGNATURE								1	
		APR 27 1995	) yells	dhudear R	well									



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			bermit. Pages 1, 2, 3		
	15-0020	ttending physician.	e as the burial-transit		
	ARYLAND 212	ned by the hospital or a	ould be detached for us	fled at once.	
	TIMORE, MA	th. Page 6 may be retai	eral director, page 5 sh	miner must be notif	
(	ON OF VITAL RECORDS, P.O. BOX 68760	INIS PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.	After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 Seath with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
	O. BOX 6876	ertificate be executed w	ing physician and comp rgiene prior to burial, cr	other traumatic eve	
	ECORDS, P.	equires that the death of	in signed by the attend of Health and Mental Hy	nows any injury, or	
	OF VITAL R	PHYSICIAN: The law re	this certificate has been with the State Dept. o	rked, or Item 23 sh	
	DIVISION	TO THE HOSPITAL OR ATTENDING	TO THE FUNERAL DIRECTOR; After be filed within 72 hours after death	APORTANT: If Item 28 is ma	
		TO THE HOS	TO THE FUNI be filed withi	IMPORTAN	

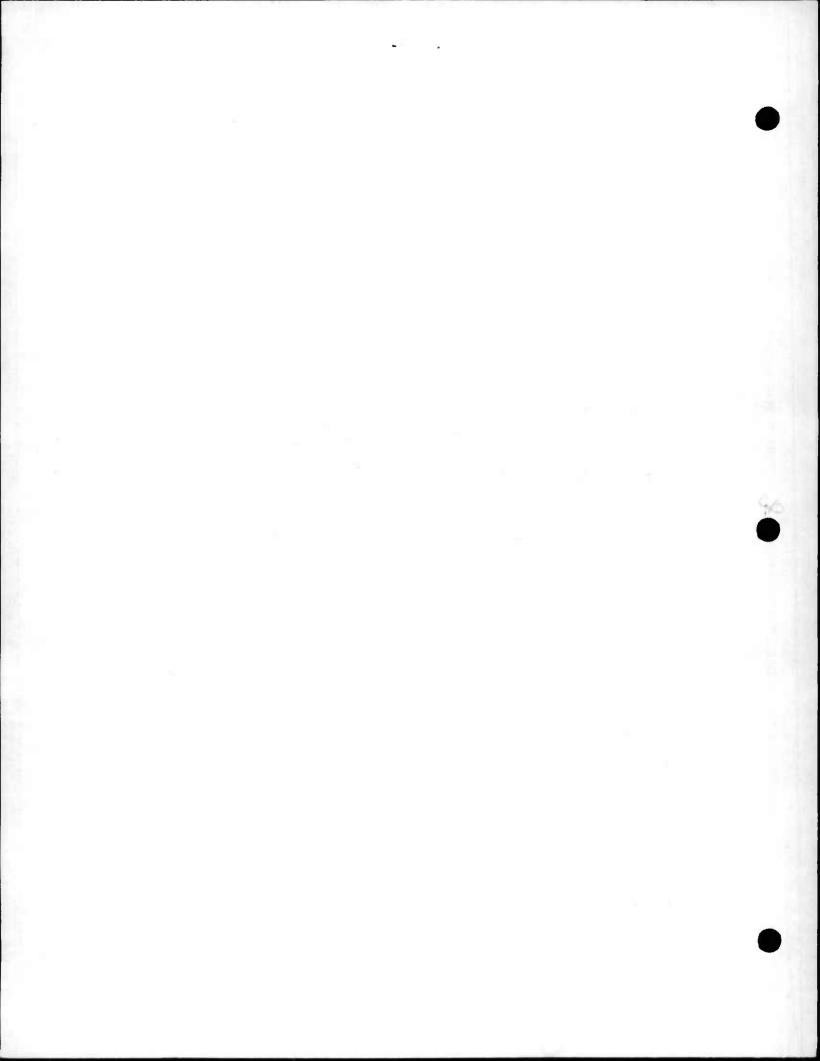
Krishan Mathur,
31. DATE FILEO (Month, Day, Year)
APR 2 6 1995

1995

M.D.

32. BEGSTRALE SIGNATURE COOL

							2	1 10403			
	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT O	F HEALTH AND N		E				
į.	1. DECEDENT'S NAME (First, Middle, Last)		CERTIF	ICATE	DE DEATH	REG. NO.		3. TIME OF DEATH			
	Donald Ala	an	Bull			April 22	,199	9:10 a.m			
Û	4. SOCIAL SECURITY NUMBER 080-26-1806		(In yrs. lest birthday)	IF UNDER 1 YE	AR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)			
	9a. FACILITY NAME (If not institution, give st		60 YRS.			July 25,	934	NY			
Œ			nitol		wn or location of de Plata	ATH	11.	ry of death rles			
CTO	Physicians Men										
DIRECTOR	MD 106. COUNTY			Y, TOWN OR LI	OCATION			10d. INSIDE CITY LIMITS?			
	10e. STREET AND NUMBER			ssue	101, ZIP CODE		10a, CITIZ	1 YES 2 NO EN OF WNAT COUNTRY?			
FUNERAL	11215 Keokee Ct				20645			U.S.A.			
FU	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER I	N U.S. ARMED 2 NO	13. WAS	DECENDENT OF NISPAN	C ORIGIN? (Specify Yes	or No-	14. RACE — American Indian, Black, White, atc.			
В	3 Widowed 4 Divorced	1955-1962	ATES		YES 2 XNO Specify:		Specify: White				
ED	15. DECEDENT'S EDUC (Specify only highest grade	CATION	16a, DECEDENT'S	USUAL OCCU	PATION	16b. KIND OF BUS	SINESS/INDU	STRY			
E	Elementary(Secondary (0-12)	College (1-4 or 5 +)	Consu		most of working						
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	7	Consu	rtant	40 MOTHERS NAM	AV1	atio	n			
BE C	Walter B. Bull	-				.ce Dash	,	11			
TO B	19a. INFORMANT'S NAME (Type/Print) Barbara W. Bul	1	19b. MAILING	ADORESS (Str	eet end Number or Rural A	oute Number, City or Tow.	n, Stete, Zip (				
-			P.0	. Box	70 Issue						
	20e METHOD OF DISPOSITION  1 🖰 Burlet: 2 🗌 Cremation: 3 🗎 Remo 4 🗐 Donation: 8 🖨 Other (Specify)	oval from State	PLACE AND DATE	OF DISPOSITION	Cem Ann	OATE 20c. LO	CATION — C	ny or Town, State e Mountain, N			
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	110 4.	22 NAN	E AND ADDRESS OF FAC	41 47,7J	DIU	e Mountain, N			
, j	► Havid C. E	Thols N	100945	P.(	SHAKT-ECH ). Box 56	OLS FUNE 7 LaPLat	RAL	HOME, INC.			
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate										
	anock, or heart failure. List only one cause on each line.										
	disease or condition disease or condition a. CAYER OF LUNC 300 a.  DUE TO (OR AS A CONSEQUENCE OF):										
_	DUE TO (OR AS A CONSEQUENCE OF):  METASTATS  C										
티	Sequentially list conditions, if any, leeding to immediate  DUE TO (OR AS A CONSEQUENCE OF):										
Ş	CAUSE (Disease or injury										
CERTIFICATION	that initiated avents reaulting in death) LAST	DUE TO (OR AS )	CONSEQUENCE O	F):							
8	PART II Other significant condition										
B	PART II. Other aignificant condition	Contributing to death E	out not resulting	in the under	ying couse given in F	PERFOR	MEO?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DF CAUSE			
E E	1 Tes 2 NO OF DEATN?										
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTR	RIBUTE TO CAUSE C	F DEATH YE	S   NO	☐ UNCERTAIN			1 TYES 2 NO			
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HQSPITAL:	28. PLACE OF DEA	TN (Check only o	one)						
HYS	1 UPS 2 NO Unpatient 2 ER/Outpatient 3 DOA 4 Uning Nome 5 Residence 6 Other (Specify)  27. MANNER OF DEATH  286. OATE OF INJURY  286. TIME OF 28c. INJURY AT 26d. DESCRIBE NOW INJURY OCCURED										
	Netural 5 Pending	(Month, Day, Year)	IN.	JURY	WORK?	26d. DEŞCRIBE NOW II	SO. DESCRIBE NOW INJURY OCCURED				
D BY	3 Suicide 6 Could not be 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)										
COMPLETED	4 Homicide determined										
MPL	29e. CERTIFIER (Check only 2 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and menner as attated, one)  2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and menner as attated.										
00	2 MEDICAL EXAMINER		n end/or investigation	en, in my opinic	n, death occured at the t	lme, dete end place, en	d dus to the	couse(e) and manner ea stated,			
BE	296. SIGNATURE AND TITLE OF CERTIFIER	M. MOT	ha-		29c. LICENSE NUM		29d. DATE	SIGNED (Month, Day, Year)			
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE OF DE	ATN (ITEM 27) (Type	. Print) 1 1	D-28352		1	1 + 1 ( 7 )			
80. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 11340 Pembrooke Square, Suite Krishan Mathur, M.D. Waldorf, Maryland 20603											
- 1				11 CI	- 4 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	- Y LUILU Z					

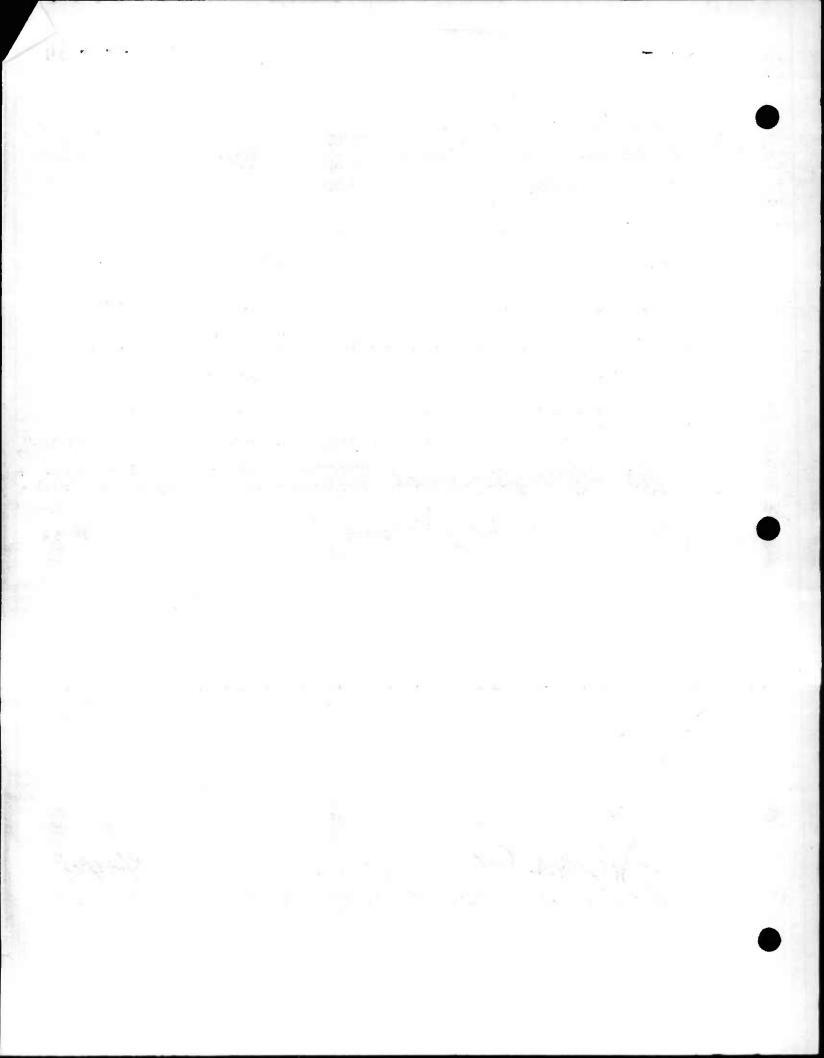


1 - STATE REGISTRAR
1. DECEDENT'S NA
Joseph
4. SOCIAL SECURIT
721-18-
9a. FACILITY NAME
508 Rac
RESIDENCE O
Maryla
10e. STREET AND N
508 Ra
11. MARITAL STATU
1 Never Married
3 Widowed 4

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO.

			O.L	-111111	CAIL	JE DEA	117	MEG. NO.					
1	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATN		3. TIME OF DE	ATH		
	Joseph Emerson	Bell					- 1	April 9,	199	5 2:30	n #		
- 8	4. SOCIAL SECURITY NUMBER	t birthday)	IF UNDER 1 YE	AR IS IMPE		7. DATE OF BIRTH		BIRTNPLACE (Store or					
1				YRS.	MONTHS DA		MIN.	(Month, Day, Year)		Country)			
		1X M 2 □ F	84	THO.			Į.	lug. 26,	1910	Maryla	and		
	9a. FACILITY NAME (If not institution, give stre	et end number)			9b. CITY, TO	WN OR LOCAT	ION OF DEAT	rn .	9c. COUNTY	OF DEATN			
<u>بر</u>	508 Race Street			- 1	Vi	enna			ח	orcheste	r		
DIRECTOR	RESIDENCE OF DECEDENT					CIIIIG				renesce	L		
ĬĮ.	10e. STATE 10b. COUNTY			10c. CITY	, TOWN OR L	CATION			10d, INSIDE CI	TY			
5	Maryland Do	mah a a t a -			37.5					LIMITS?			
31	10e. STREET AND NUMBER	rchester			Vie					1 X YES 2			
*	acourst. Continues					10f. ZIP COD	E		10g. CITIZEI	N OF WHAT COUNTRY	?		
<u>u</u>	508 Race Stree	t				21	869		1	U.S.A.			
FUNERAL		12. WAS DECEDENT E			13. WAS	DECENDENT	OF HISPANIC	ORIGIN? (Specify Yes		. RACE — American In Black, White, etc.	dlen,		
-	1 Never Married 2 X Married	FORCES? 1	OR DATES	10	If yes	YES 2 X NO	ın, Mexicen,	Puerto Ricen, atc.)		Black, White, etc.			
B	3 Widowed 4 Divorced		OII DAILE		1	LES & ER HO	Specify:			Specify: White			
0	15. OECEDENT'S EDUCA	TION	16a. DE	CEDENT'S	USUAL OCCUI	ATION		16b. KIND OF BUS	INCOCUNDUO				
E	(Specify only highest grade co		(G/	ve kind of w	ork done durin	most of worki	ng	100. KIND OF BUS	INESS/INDUS	181			
ا ت	Elementary/Secondary (0-12)	College (1-4 or 5+)	200		100000								
2			Clr	ager	asn	naule	auler elect		ric	power			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					16. MOT	HER'S NAME	(First, Middle, Maiden	Surname)				
	Joseph Bell						Le	na Murph	V				
BE	19a. INFORMANT'S NAME (Type/Print)		104	MAILING	ADDRESS (C)			ute Number, City or Town	-				
2	and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s										- 1		
. 1	Mabel L. Bell			08 K	ace S	t.,	lenr	na, MD.	51869	i .	1		
	20e. METHOD OF DISPOSITION  1 N Buriel 2 Cremetion 3 Remov	0.2000	20b. PLACE A	ND DATEO	FDISPOSITIO	Name of		DATE 20c. LOC	CATION City	y or Town, State			
	4 Donation 5 Other (Specify)	al from State	cemetery, cret	natory or oth	Marke	t Cer	n 4-	12 East	Now	Market,	MD		
1	21. SIGNATURE OF FUNERAL SEMUCE LICEN	NSEE /	P400		22 NAM	E ANO ADDRE	00.05.5100	TZ Pabe	110 #	Hat Kee/			
	4	1							neral Home, P.A.				
	Abelies Hille	4-19M	11110	00									
	23. PART I. Enter the diseases, or co	moltcations that or		ath David	-608	High	SE	Cambri	age,	MD. 216			
	shock, or heert fallure. Li	st only one ceuse	on each line.	etn. Do n	or enter the	mode or dy	ing, such	ea cerdiec or reapir	ratory arrea		mate Between		
J	IMMEDIATE CAUSE (Finel	17	_								nd Death		
1	disease or condition	DUE TO (OR	1 C	an						11/			
H	resulting in death) a.	DUE TO (OR	AS A CONSEC	HIENCE OF						Year	-)		
- 1		552 10 (61)	N CONSEC	DENCE OF	,.								
8 1	Sequentially list conditions, b.												
Ĕ	If any, leading to immediate	DUE TO (OR	AS A CONSEC	UENCE OF	):						1		
CERTIFICATION	CAUSE (Disease or injury										- 1		
	that initiated events	DUE TO (OR	AS A CONSEQ	UENCE OF	):								
듄	resulting in death) LAST												
81	a.												
	PART II. Other algnificent conditions	contributing to dec	th but not re	eulting in	the under	ying ceuse	given in Pa	ert I. 24s. WAS AN	WITOPSY	24b. WERE AUTOPSY	FINDINGS		
MEDICAL								PERFORI		AVAILABLE PRIO	R TO		
ō								1 YES 2	NO NO	COMPLETION OF OF DEATH?	CAUSE		
¥ .								_   _ ′		1 TYES 2	NO		
-	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN												
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 1  25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)												
ō I		HOSPITAL:			OTHER:								
₹ S	1 VES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Realdence 6 Other (Specify)												
£ 1	27. MANNER OF DEATH  28a. DATE OF INJURY (Month, Day, Year)  28b. TIME OF INJURY AT WORK?  28c. INJURY AT WORK?									ED			
	1 Natural 5 Pending	(	·	11100		YES 2	NO				- 1		
B√	2 Accident Investigation 3 Suicide 8 Could not be 28s. PLACE OF INJURY — At home, farm, street					Hino		ed a control (o)	and Number or Rural Route Number,				
	8 Could not be	reet, rectory,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-   *	City or Town, State)	and Number of Hurst House Number,							
10													
COMPLETED	29a. CERTIFIER Check only	AN: To the best of my	knowledge, des	th occurred	at the time.	dete end place	and due to	the cause(a) and man	nor on eleteri				
2	one) 2 MEDICAL EXAMINER:										EURE .		
8 1	The same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa		TARIOTI WINGTON II	watigation	, iii niy opinio	n, oeann occui	red at the tin	ne, data and place, and	due to the c	Juse(a) and menner as	stated.		
H	296. SIGNATURE AND TITLE OF CERTIFIER	, /				29c. LICI	ENSE NUMBE	ER	29d. DATE SI	IGNED (Month, Day, Year	7)		
	the Mil	4				D 3	3476	0	D 44	121115	- [		
일	30. NAME AND ACCURES OF PERSON WHO	COMPLETED CALLES O	E DEATH /ITEM	270 /%	Deline)	1-10	1/6	0	-/	(27/7)			
	_ / /							0-1: :			, 1		
	Jeffrey M. Wiel				vers	rae D	r.,	Salisbur	y, MI	2180	Τ		
	APR 2 5 1995	PREGISTRAR'S	SIGNATURE										
	7 7 7 7 1995	yeur attends	orhanda	Щ							- 1		
. 11		40											



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	NDING PHYSIC T. After this control of death with the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of th	CIAN: The law	ertificate has by	or item 23

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31. DATE FILED (Mor

APR

1995 9

**BALTIMORE, MARYLAND 21215-0020** 

DIVISION OF VITAL RECORDS, P.O. BOX 68760

13465 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Leat) 2. DATE OF DEATH 3. TIME OF DEATH APRIL 07 1995 7:00 **JEFFERY** BURBRIDGE P В. 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) Quincy, DAYS 1 X M 2 | F 539-52-6281 44 October 23,1950 Illinois Se. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 1994 STILLWATER ROAD DIRECTOR CARROLL ELDERSBURG 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's College Park 1 X YES 2 | NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? United States of America 9736 Wichita Avenue 20740 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ∑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES WAS DECEMDENT OF HISPANIC ORIGIN? (Specify Yee or No If yee, specify Cuben, Maxican, Puerto Rican, atc.)
 U YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried BY Specify: 3 Widowed 4 Divorced 1972-1978 White 16a. DECEDENT'S USUAL OCCUPATION

Make Alone during most of working COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life, Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Aviation Instructor Aviation Education 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Ralph Burbridge Gail Valandingham BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Michael Burbridge (Brother) 7763 Sleepy River Way , Sacramento, CA 95831 20b. PLACE AND DATE OF DISPOSITION (Name of Care matory 47 F 4 1995 20c. LOCATION - City or Town, State Camellia Memorial Lawn □ Donation 8 □ Other (Specify) Sacramento, California OF FUNERAL SERVICE LICENSEE 21 SIGNATUR #M00690 22. NAME AND ADDRESS OF FACILITY A. J. Nicoletti, Inc. 5401 Folsom Blvd., Sacramento, CA 95819 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate ahock, or heart feliure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Finel Onset and Death disease or condition_ MULTIPLE INJUPLES reaulting in death) CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART II. Other algoriticent conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL YES 2 NO 1 Inpatient 2 I ER/Outpatient SCENE 280. DATE OF INJURY 417/95 Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DEŞCRIBE HOW INJURY OCCURED 5 Pending 1 YES PLANE CRUSH BY Accident Investigation 28e. PLACE OF INJURY — At home, building, etc. (Specify) 281. LOCATION (S treet and Number or Rural Route Number, ED 8 Could not be PRONT 4 Homicide determined AWN WATER KID ELDERS BEIG STALL COMPLET 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated. (Check only one) 2 MEDICAL EXAMINER investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end manner as stated. 19c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year, BE ▶APRIL 08,1995 O.C.M.E.

111 PENN STREET, BALTIMORE, MARYLAND 21201

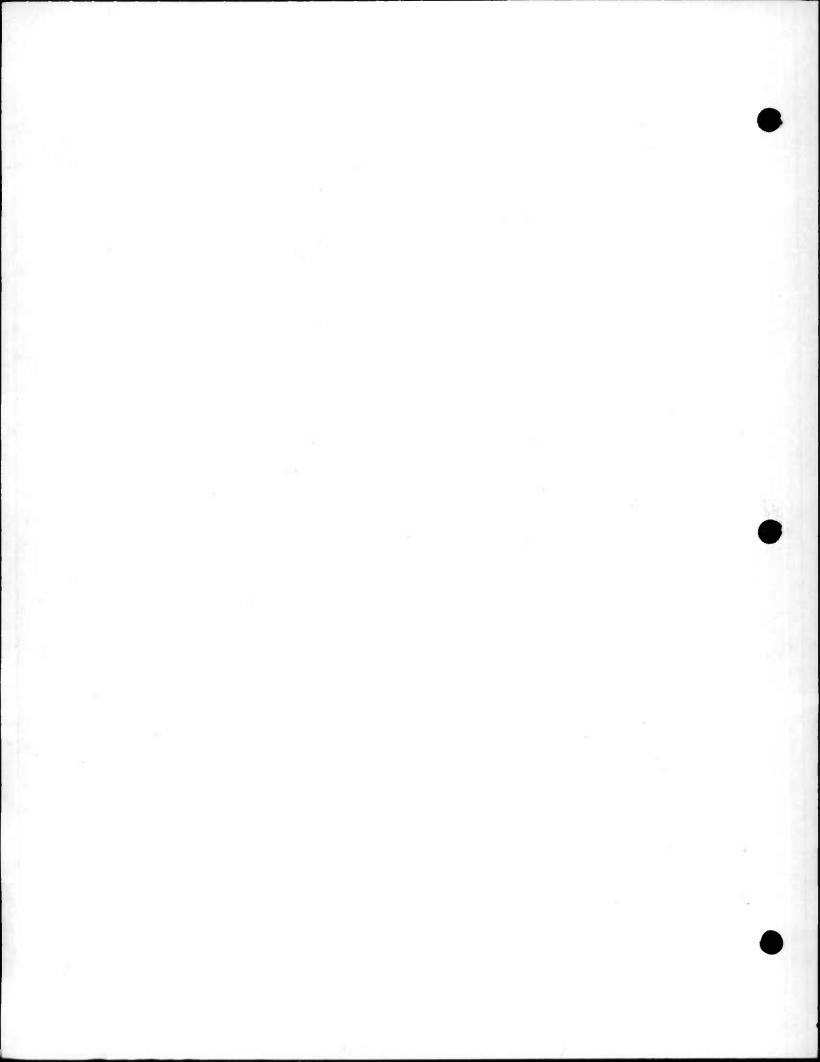
COMPLETED CAUSE OF MEATH (ITEM 27) (Type, Print)

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TO THE HOSPITA
TO THE FUNERA
F filed within 72
IMPORTANT: II

HOSPITAL FUNERAL I

DHMH-18 Rev 1/89



DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020
10 HF HUSHING MINISTERMAN FROM THE LAW REQUIRES THAT THE GRAIT CENTRICATE DE GREGOLIED WITHIN 24 NOUS After Geally. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept. of Health and Mertial Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

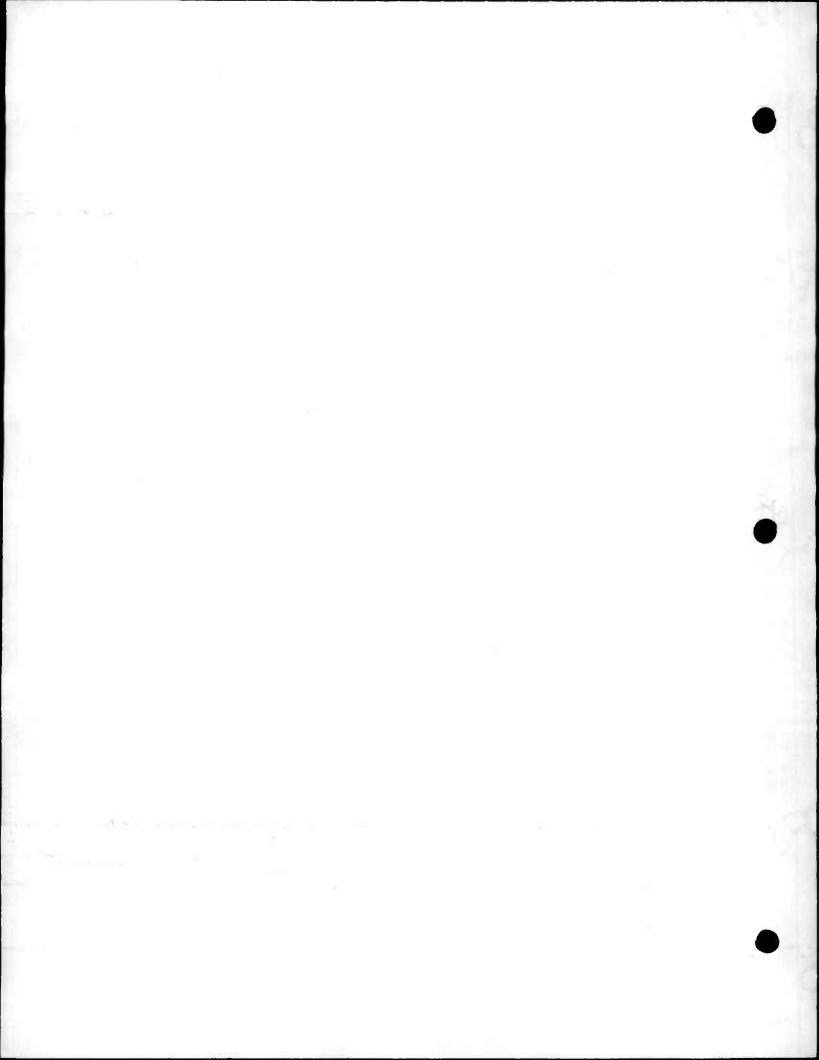
								95		3400		
	1 - FOR STATE REGISTRAR	STATE OF MARY				EALTH AND DEATH	MENTAL HYGIEN REG. NO.	E				
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF OEATH			3. TIME OF DEATH		
Ш	GREGORY		BROOKS	5			MARCH 30		995	11:10 PM		
	4. SOCIAL SECURITY NUMBER 5.	. SEX 6. AG	E (In yrs. lest birthde	y) IF UNDE	R 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		8. BIRTI	HPLACE (State or Foreign		
	230-94-7169	TxM 2 □ F 3	8 YRS	MONTHS	DAYS	HOURS MIN.	(Month, Day, Year) March 22,	105	7 T	**		
	Se. FACILITY NAME (If not institution, give street			9b. CIT	Y, TOWN C	R LOCATION OF D			INTY OF C			
Œ	PRINCE GEORGE'S	HOSDITAI	CENTED	CII		TAZ MAD	VI AND	DDT	MOR	CEODOR		
DIRECTOR	RESIDENCE OF DECEDENT	HODITIAL	CENTER	CH.	EVER	LY MAR	ILAND	PKI	NCE	GEORGE		
Ä	10a. STATE 10b. CDUNTY		10c. 0	HTY, TOWN	OR LOCAT	ION				10d. INSIDE CITY LIMITS?		
Ö	Maryland Prince	e George	La	ndov	erhi	.11s Ma	rvland			1 X YES 2 ND		
AL	Maryland   Prince George   Landoverhills Maryland   15   15   160. STREET AND NUMBER   100. CITIZEN DF WHAT									WHAT COUNTRY?		
ER.	3907 Landoverhil	11 g				20784		TT S	5 . A .			
FUNERAL		. WAS DECEDENT EVE	R IN U.S. ARMED	13.			NIC ORIGIN? (Specify Yes		14. RAC	E — American Indian,		
	1 K Never Married 2 Married	FORCES? 1 YE			If yes, sp	2 X NO Specific	in, Puarto Rican, atc.)		Blac Spec	ck, White, etc.		
B	3 Widowed 4 Divorced					2 22 110 0,000	7-		BL	ÄCK		
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con		16a. DECEDENT	'S USUAL	OCCUPATIO	N .	16b. KIND OF BUS	b. KIND OF BUSINESS/INDUSTRY				
ET		College (1-4 or 5+)	life. Do NOT	use retired.	during mo	st of working						
P	12		Manage	er Bu	ırge	r King	FAST	FOOI	SE	RVICE		
O	17. FATHER'S NAME (First, Middle, Last)						ME (First, Middle, Maiden	Surname)				
	LEON L.BROOKS						NEWTON B		S			
BE	19a. INFORMANT'S NAME (Type/Print)		19h MAII I	NG ADDRES	e /Street e		Route Number, City or Tow					
2		OKS								20784		
	EDITH NEWTON BROOKS 3907 71 Avenue Landoverhills md. 20784											
	20b. PLACE AND DATE DESPOSITION  1 M Buriel 2 Cremetion 3 Removal from State 4 Donation 6 Other (Specify)  20b. PLACE AND DATE DESPOSITION (Name of commendation of the property preparatory occupier place)  20c. LOCATION — City or Town, State  20c. LOCATION — City or Town, State  20c. HOCATION — City or Town, State  20c. HOCATION — City or Town, State  20c. HOCATION — City or Town, State  20c. HOCATION — City or Town, State											
	BERRY O. WADDY											
	P.O.BOX 165 LANCASTER VA. 22503											
	23. PART I. Enter the diseases, or com	pilcetions that caus	the death. Do	not ente	r the mo	de of dying, auc	h sa cardiec or reapi	ratory a	rest,	Approximate		
	ahock, or heart fellure. List only one ceuee on ech line.											
	IMMEDIATE CAUSE (Fine) disease or condition											
. :	resulting in death)  s. O by United States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of States of											
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CERTIFICATION	Sequentially list conditions, b.	OUL TO OR A	S A CONSEQUENCE	DE	790	reince	Hegues	<i>S</i> '		The year		
F	If sny, leading to Immediate cause. Enter UNDERLYING	00E 10 (ON A.	SEC. 18 (SI) AS A CONSEQUENCE DE).									
5	CAUSE (Disease or Injury Ca	DUE TO (DR AS A CONSEDUENCE OF):										
Ē	that initiated events resulting in death) LAST					j						
岚	resulting in destri) LAST											
- 1	PART II. Other aignificent conditions of	ontributing to death	but not resultin	g in the u	nderiyin	g cause given in	Part I. 24s. WAS AN	AUTOPSY	24	b. WERE AUTOPSY FINOINGS		
2	S, of Store Kens	& Diees	28				PERFDE			AVAILABLE PRIOR TO COMPLETION OF CAUSE		
입	1 VES 2 NO OF DEATH?											
PHYSICIAN: MEDICAL	DID TORACCO LISE CONTRIBUTE TO CALISE OF DEATH VES TO NO THE LINES TAIN TO											
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN											
Ö	25. WAS CASE REFERRED TO MEDICAL EXAMINER? LOSPITAL: OTHER:											
ΥS		Inpatient 2 - ER/O		raing Hom	ome 5 Rasidenca 6 Other (Spec/fy)							
ᇤ	27. MANNER OF DEATH	28a. OATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY			28c. INJ WO	URY AT RK?	28d. DESCRIBE HOW I	Bd. DESCRIBE HOW INJURY OCCURED				
à	Netural 5 Pending 2 Accident Investigation					ES 2 NO						
	3 Suicide 6 Could not be	26a. PLACE OF INJU building, atc. (S	IRY — At home, farm pecify)	ctory, offic		Route Number,						
	4 Homicide detarmined						City or Town, State)					
7	29e. CERTIFIER 1 CERTIFYING PHYSICIAL	N: To the best of my kn	owledge, death occi	irred at the	time, data	and place, and du	to the cause(a) and ma	ner as at	ated.			
COMPLETED	enel .									(s) and manner as stated.		
V	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.											
	296. SIGNATURE AND TITLE OF CERTIFIER  29c. LICENSE NUMBER  D13987  D13987  DATE SIONED (Month, Day, Year)											
BEC	296. SIGNATURE AND TITLE DE CERTIFIER					D1398						

7525 GREENWAY CENTER #313 GREENBELT, MD.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

SIDHU

M.D. 10 1995



DIVISION OF VITAL RECORDS, P.O. BOX 13146,	BALTIMORE, MARYLAND 21203-3146
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Ars after death. Page 6 may be retained by the hospital or attending physic	after death. Page 6 may be retained by the hospital or attending physical
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial hands and within 70 hours after death with the State Den of Health and Mental Handers prior to burial committee. Or removal.	by the funeral director, page 5 should be detached for use as the buria moval.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	lical examiner must be notified at once.

ospital or attending physician. ched for use as the burial-transit permit, Pages 1, 2, 3 should

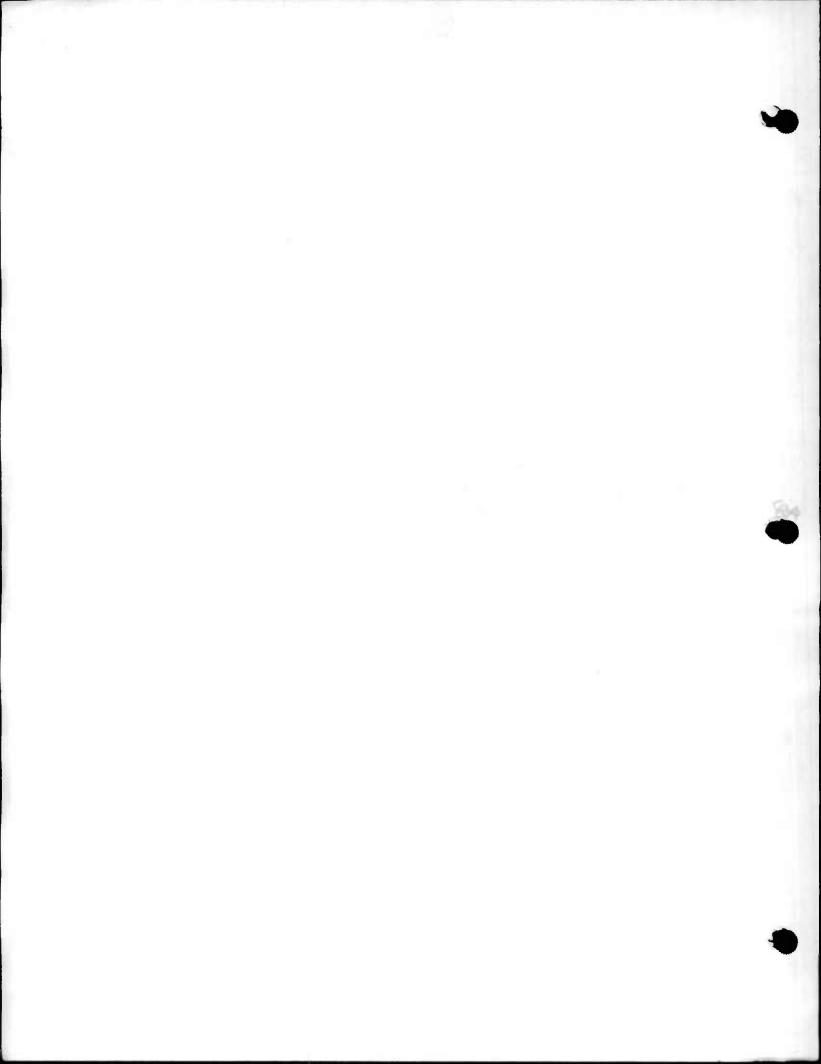
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 - STATE REGISTRAR				CEF	RTIFIC	CATE OF	DEATH	R	EG. NO.				
1. DECEDENT'S NAME (First, A	Widdle, Last)			-				2. DATE OF E	DEATH	lv.	YEAR	3. TIME OF D	EATH
JOHN HEN	RY BIA	AS						04	0		95	8:15	PM M
4. SOCIAL SECURITY NUMBER	Я	5. SEX	6. AGE	In yrs. last bi		IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF 8 (Month, De	URTH		8. BIRTH	IPLACE (State of	
578-12-9344	•	1 X M 2 - F		87	YRS.	IONTHS DAYS	HOURS MIN.	(MOTH), De	y, rosar)		Coura	.,,,	
9a. FACILITY NAME (If not insti	itution, give si	treet and number)			1	96. CITY, TOWN	OR LOCATION OF DI	EATH		9c. COL	INTY OF D	DEATH	
GREENBELT N		IG CENTER				GREENBI	ELT, MARY	LAND		PRI	NCE (	GEORGE	
10a. STATE	10b. COUNTY	1		-	10c. CITY,	TOWN OR LOC	ATION					10d. INSIDE C	ITY
MARYLAND	PR1	NCE GEOR	RGE		GREI	ENBELT	MARYLAN	D				1 X YES 2	□ NO
10e. STREET AND NUMBER						- 1	of. ZIP CODE			10g. CIT	IZEN OF	WHAT COUNTRY	7
7010 GREEN	NBELT						20777			US.			
11. MARITAL STATUS  1 Never Married 2 M  3 Widowed 4 Divorce		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES WAR OR D	2 NO		If yes, t	ECENDENT OF HISPAI specify Cuben, Mexica S 2 NO Specif	en, Puerto Ricar		or No-	14. RACI Blac Spec	E — American li k, White, etc.	adlen,
	/	7 MAY 4	2 -					T 201 1201				BLACK	
(Specify only i		completed)		(Give		SUAL OCCUPAT rk done during r retired.)		16b. KIN	D OF BUS	SINESS/IN	DUSTRY		
Elementary/Secondary (0-1	(2)	College (1-4 or 5	+)		ASTE	4000		ST	FI	TZAR	ו עידים	HOSPITA	т
17. FATHER'S NAME (First, Mid	Idle, Lest)			1 - ~ 1			18. MOTHER'S NA				ulli I	TOOF LIF	L
JAMES B1							EIZA H		.,				
19a. INFORMANT'S NAME (Typ							and Number or Rural		,				
AUDREY L. W	VRIGHT			514	4 157	TH ST S	E WASHI	NGTON,	DC 2	2000.	3		
20s. METHOD OF DISPOSITION 14 Burlel 2 Cremetion	3 🗆 Rem	ovat from Stata	200	b. PLACE OF other place	)		emetery, crematory or		20c. LO	CATION -	City or To	own, Stata	
4 Donation 5 Other (S		77			CHEI		CEMETERY		CI	HELT	AHAM.	MD	
21. SIGNATURE OF FUNERAL	SERVICE LIC	ENGEL /	1				AND ADDRESS OF FA		TEDAT	TIOI	ATP T	EMO.	
cleho.	9	Rend	21				GOOD HO						C
23. PART LEnter the dis	eases, or o	complinations the	t couse	d the deat	h. Do no	t anter tha n	oda of dying, suc	ch as cardiac	or reapi	iretory a	rreat,	Approx	imate
iMMEDIATE CAUSE (Final disease or condition resulting in death)					(1	nefab	o lic a	nd Re	50)	ra t	0-4		and Deeth
reconning in death)		DUE TO	(OR AS	CONSEQU	ENCE OF	ficie							
Sequentielly list condition						-	ncy.						
If any, leading to immedi	lete	DUE TO	(OR AS	A CONSEQU	ENCE OF)								
cause. Entar UNDERLYIN CAUSE (Disease or injury		C	(OB AS	A CONSEQU	ENCE OF								
that initiated events resulting in death) LAST		DOL 10	(011 70 )	CONSEGO	ENOL OI ,								
	-	d											
PART II. Other significen									. WAS AN	AUTOPSY	241	b. WERE AUTOPS	IOR TO
Kest-ic'	live	and C	55	Youc	Tiv	e rul	m079-1	1 1	YES 2	v		COMPLETION I	OF CAUSE
Disease	, <i>\forall </i>	rpe- te	nsi	07,		e me	1/19.					1 TYES 2	No
25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:				26. QTHER:	PLACE OF DEATH (C)	heck only one)					
1 TYES 2 HO		1 Inpatient 2			DOA	Nursing H	ome 5 Residence						
27. MANNER OF DEATH  1 X Netural 5 P	ending	28a. DATE Of (Month, I	F INJURY Day, Ybar)		28b. TIME INJU	RY 1	NJURY AT VORK?	28d. DEŞCRI	BE HOW I	INJURY O	CCURED		
2 Accident in	westigation	28a BI ACE /	At IN HIM	V _ & har-	a farm c	m 1 _	YES 2 NO	201 1 000710	N (Co	and Mi	w or D	Brute Mush-	
	could not be etermined	building	, etc. (Spe	elfy)	v, rarM, SC	reet, mactory, of	iice		wn, Stete)		er Or MUNII	Floute Number,	
29a. CERTIFIER 1 CERTI	FYING PHYS	CIAN: To the heat o	f my know	riados dasti	h occurre	at the time of	its and place, and du	a to the council	) and ma	nner ee	atad		
(Check only							, death occured at the					(a) and manner	as stated.
0	ор сцатичн		,	1			29c. LICENSE NU			_		D (Month, Day, Y	
87.7	/	- K	7	M	1			001		<b>D</b>	4/1	0/95	='
30. NAME AND ADDRESS OF	PERSON WI	O COMPLETED CAN	OF DI	EATH (ITEM	27) (Type. )	Print) 7	00 6-00	I	( ,,	7-	0-	Tt:42	~
Stuart To	urke	write.	X-1.1	>.	, , , , , , ,	Gre	on Gee	Y Ma	1. 2	07	70	41-43	
APR 11 1995	sur Sal	32. REGISTR					,			-			



FOR STATE

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

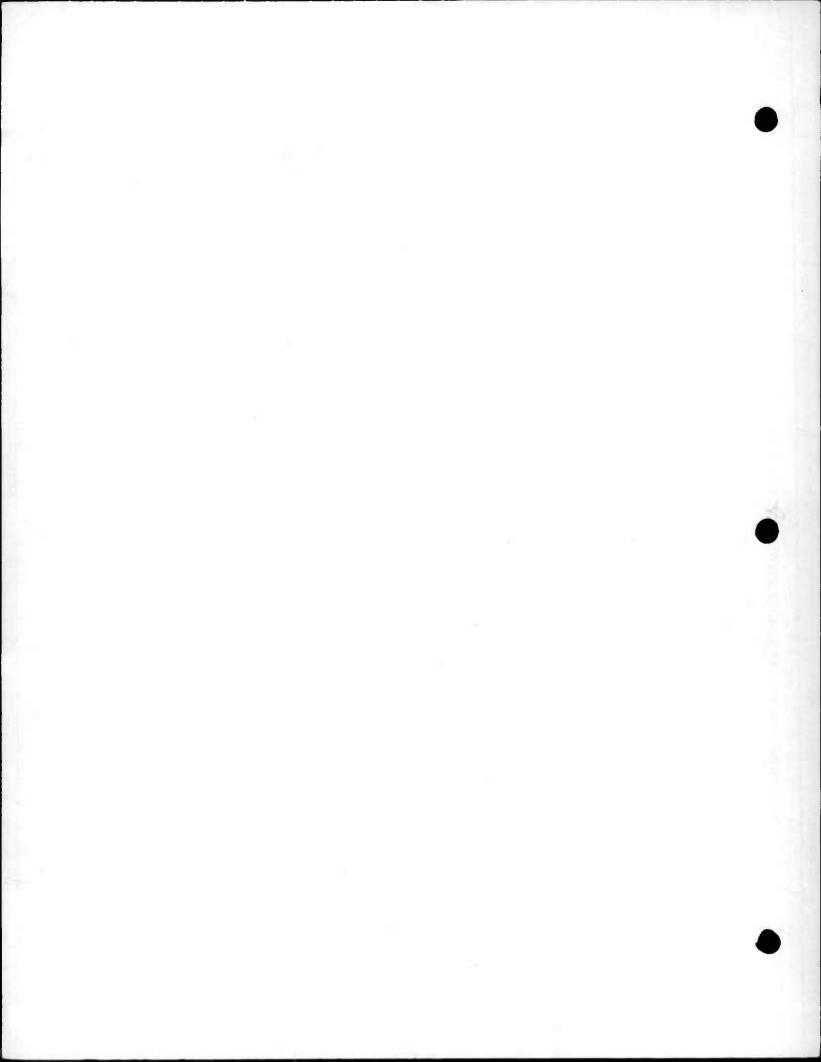
		IFICATE (	OF DEATH	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Lost)  ROBERT LEE BABB	1 7		2. DATE OF DEATH MONTH DA	95 YEAR	3. TIME OF DEATH 7:25 P M	
	4. SOCIAL SECURITY NUMBER 224-86-8534 S. SEX 6. AGE (In yrs. last birtho	MONTHS DA		7. DATE OF BIRTH (Month, Day, Year)	8. BIRT Coun	HPLACE (State or Foreign try)	
	9a. FACILITY NAME (If not institution, give street and number)	9h CITY TO	WN OR LOCATION OF DEA	9-24-5	9c, COUNTY OF	FOLK, VA.	
DIRECTOR	HYATTSVILLE MANOR NURSING HM.		ATTSVILLE		P.G		
EC	The same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa	CITY, TOWN OR L	DCATION			10d. INSIDE CITY	
	MD PRINCE GEORGES C	APITOL	HEIGHTS			LIMITS?  VES 2 NO	
FUNERAL	404 QUARRY AVENUE		20743		10g. CITIZEN OF U.S	• A •	
ΒY	11. MARITAL STATUS 1 Never Merried 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	If ye	DECENDENT OF HISPANI a, specify Cuban, Mexican YES NO Specify:	C ORIGIN? (Specify Yes , Puarto Rican, etc.)	Spec	E — American Indien, ik, Whita, etc. ifly: ACK	
9	15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Give kind	IT'S USUAL OCCU	PATION	16b. KIND OF BUS		ACK	
COMPLETED	(Specify only highest grade completed)  Elementary/Secondary (0-12)  12TH  (Give kind of work done during most of working life. Do NOT use retired.)  NURSING ASSISTANT  ST. ELIZABETH						
OM	17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAM	IE (First, Middle, Malden S			
BE C	WALTER BABB			ELEN MULI			
5	19a. INFORMANT'S NAME (Type/Print)  MAURICE JOHNSON  19b. MAIL 404	OUARRY	eet and Number or Rural Ro AVE - CAF	PT - HEIGH	State, Zip Code)	20743	
	20a. METHOD OF DISPOSITION  1	or other place)	NTON	4	CATION — City or To		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	77 22. NAM	CEMETER E AND ADDRESS OF FAC YLOR'S FI	ILITY		NE, MD	
	Duck Suckland		NORTH C			DC 20001	
	23. CART I. Enter the diseases, or complications that caused the death. Death ahock, or heart failure. List only one cause on each line.	o not enter the	mode of dying, auch	es cardiac or reapir	atory arrest,	Approximate Interval Between	
	IMMEDIATE CAUSE (Finel disease or condition	Mur 1	Ween	a synd	Mu	Onset and Death	
	resulting in death)  a. Due to (on as a consequence	E OF):	()	9		N Wh	
NO	Sequentially list conditions,		V	1 1			
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	E OF):					
E	CAUSE (Disease or Injury that initiated events Due to (on as a consequence	E OF):					
EH	resulting in death) LAST						
- 48	PART II. Other eignificant conditions contributing to death but not resulting	ng in the under	ying cause given in P	art I. 24a. WAS AN A	AUTOPSY 248	WERE AUTOPSY FINDINGS	
EDICAL	mating & wally of	renu		PERFORM	WE07	AMILABLE PRIOR TO COMPLETION OF CAUSE	
MEC	incipal phone					OF DEATH?	
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH					00 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min ( 100 min	
PHYSICIAN:	EXAMINER? HOSPITAL:	OTHER:	View Commission Co.				
H	1 ☐ YES 2 ☐ 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DO: 27. MANNEJS-OF DEATH 288. DATE OF INJURY 288.	and the second	Home 5 TResidence 6	Other (Specify) 28d. DESCRIBE HOW IN	HIRK OCCURED		
ВУ Р	1 Natural S Pending (Month, Day, Year)	INJURY	WORKY	and Describe HOW IN	JUHY OCCURED		
ED B	3 Suicide 8 Could not be 28s. PLACE OF INJURY — At home, far building, etc. (Specify)	m, street, factory,	office	28f, LOCATION (Street or Oily or Yours, State)	nd Number or Rural I	Noute Number:	
E	4   Homicide determined			Cont. or commit animal			
COMPLET	28a. CERTIFYING PHYSICIAN: To the best of my Jagmedge, death occurred by 2 MEDICAL EXAMINER: On the basis of examination and/or investig					and manner as stated.	
BE C	280. AGNATURE AND TITLE OF CENTERN	Inst	20c. LICENSE NUME	allocat Extlantermina and inte	29d. DATE SIGNED	1-2000 127 (2011 (217 20 C C C C C C C C C C C C C C C C C C	
2	34. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (1	ype, Print)	1 DULY		- 4	. 11/11/4	
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	M. 20	184				
	APR 12 1995 July Davidson Rendall						

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a flore death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.



## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	REGISTRAR	CE	RTIF	CATE OF	DEATH	A	EG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)				· ·	2. DATE OF				3. TIME OF D	EATH
	HELEN H.	BALLIN				Apr	20.		5 YEAR	1:10	Рм
		SEX 6. AGE (In yrs. last	birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF S	HETH	- 1		PLACE (State or	
	219-34-6460	□ M 2 [XF 94	YRS.	MONTHS DAYS	HOURS MIN.	NOV 2	y, Year)	ann	Countr	y)	
	Sa. FACILITY NAME (If not institution, give street a	and number)		9b. CITY. TOWN C	OR LOCATION OF DI	FATN	-,		NTY OF D	PA	
Œ.	FROSTBURG VILLAGE	NURSING HOME		FROSTBU		CATT			LEGAI		
2	RESIDENCE OF DECEDENT										
Ä	10e. STATE 10b. COUNTY		10c. CITY	TOWN OR LOCAT	ION					10d. INSIDE C	ITY
ā	MD Allega	ny	Cun	berland						LIMITS?	□ NO
A	10a. STREET AND NUMBER			101	. ZIP COOE			10o. CITI	ZEN OF W	HAT COUNTRY	
E	900 Camden Avenue				21502			USZ			
FUNERAL DIRECTOR	11. MARITAL STATUS 12.	WAS DECEDENT EVER IN U.S. ARI	MED		ENDENT OF NISPAI	NIC OBIGINS (S	nacify Van			— American Ir	41
F	1 Never Married 2 Married	FORCES? 1 YES 2 NO. IF YES, GIVE WAR OR OATES	0	If yes, spe	2 X NO Specifi	n, Puarto Ricar	, atc.)	01 110-	Black	, White, atc.	renary,
B	3 🔀 Widowed 4 🗆 Divorced	TEO, GITE INTO ON ONIES		1 1 768	2 12 NO Specif	y:			Speci	vhite	
	15. OECEDENT'S EDUCATIO		CEDENT'S L	ISUAL OCCUPATIO	ON	18b. KIN	D OF BUS	INESS/INC		VILL CE	
ш	(Specify only highest grade comp	(Gin illege (1-4 or 5+)	ve kind of we Do NOT use	ork done during mo: retired.)	st of working						
립	12		rse			Н	ospit	tal			
COMPLETED	17. FATNER'S NAME (First, Middle, Last)				18. MOTNER'S NA						
	John J. Havliche	ek				Wande		our name,			
BE	19a. INFORMANT'S NAME (Type/Print)	196	MAILING	AODRESS (Street a	nd Number or Rural			Ctate 7/e	Carle		
5	Marguerite Hughes										
	20a. METHOD OF DISPOSITION 1  Burlel 2  Cremetion 3  Removal 1	20h BLACEA		DISPOSITION (Na	eet; Fro	OATE	, MIL	ZI	532	2000	
	1 Donation 8 Other (Specify)	rom State cemetery, crem	natory or oth	er place)		04/21					
	21. SIGNATURE OF FUNERAL SERVICE LICENSE	E SILLUI	SDULC	Cremat	OF LUITE D ADDRESS OF FA		DIIL	LUISL	urg,	MID	
	1 7	1.		Scarp	elli Fun	eral H	ome				
	Ugnas 7 d	XICarpu	11	Cumbe	rland, M	D 215	02				
	23. PART . Enter the diseases, or comp	lications that caused the des	th. Do no	ot enter the mod	de of dying, suc	h as cerdiec	or respir	ratory arr	est,	Approxi	mete
	shock, or heart failure. List of IMMEDIATE CAUSE (Final	only one cause on each line.									Between nd Death
	disease or condition	Consultion 11	00.01	10.18	esal.					Onest a	nd Death
i	resulting in death)	DUE TO (OR AS A CONSEO	UENCE OF	few						may	year
2		DUE TO (OR AS A CONSEO Conjumu DUE TO (OR AS A CONSEO	Can d	a iman of	11.5					due dod	le o
CERTIFICATION	Sequentially list conditiona, if any, leeding to immediate	DUE TO (ON AS A CONSEC	UENCE OF)		wing.					True !	Jenn
8	cause. Enter UNDERLYING			U							<u> </u>
Ē	CAUSE (Disease or Injury that Initieted events	DUE TO (OR AS A CONSEC	UENCE OF)							-	
토	resulting in death) LAST										
	DARKE II ONL									1	
EDICAL	PART II. Other significent conditions con	ntributing to death but not re	sulting in	the underlying	cause given in	Part I. 24a.	WAS AN A		24b.	WERE AUTOPSY AVAILABLE PRICE	
8 1	Ofinisiu	Jour giseen				_ 1	YES 2			COMPLETION OF	
ME		<u> </u>								1 YES 2	1 NO
	DID TOBACCO USE CONTRIBU	ITE TO CAUSE OF DEAT	H YES		UNCERTAIN	1 1 <del>2</del> 2					
X	25. WAS CASE REFERRED TO MEDICAL	26. PLACE		(Check only one)		T					
S	I NO	SPITAL: Inpatient 2 - ER/Outpetient 3 (	DOA	OTHER:	5 - Residence	e 🗆 Other /Sou	noife)				
PHYSICIAN:	27. MANNER OF GEATH	28e. DATE OF INJURY	28b. TIME	OF 28c, INJL		28d. OESCRIB		JURY OCC	URED		
	1 Natural 5 Pending	(Month, Day, Year)	INJU		RK? ES 2 NO						
À	2 Accident Investigation 3 Suicide Could not be	28e. PLACE OF INJURY — At hom	e, farm, atr			28f. LOCATION	V (Street or	nd Number	or Dural D	nuto Mumbos	
	4 Nomicide 8 Could not be	building, etc. (Specify)		, ,		City or Tov	vn, State)	TO PROTECTION	Ur nurai ni	odie iyamber,	
COMPLET	29a. CERTIFIER		-								
₹ I	(Check only CENTIFYING PHYSICIAN:	To the best of my knowledge, dear									
Ş I	2 MEDICAL EXAMINER: On	the basis of examination and/or in	vestigation,	In my opinion, de	ath occured at the	time, data and	placa, and	dua to the	e cause(s)	and manner as	stated,
H	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUM			29d. DATE	SIGNED	(Month, Day, Yea	r)
100	Thedin		13		D2690	7		<b>&gt;</b> 1	4/20	191-	
2	ODY. Harjit Sighu, M	APLETED COUSE OF DEATH ITEM	27 199	EN Posa	Cimbox1	and Mr	) 21	502	1	( )	
		Jas Distop	wal	on road	Cumber To	uia, ML	, 21	.502			
	31. DATE FILED (100) 200 1905	32 AGGISTRAR'S SIGNATURE	0.4								
- 1		THE PROPERTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF TH	大汉里								

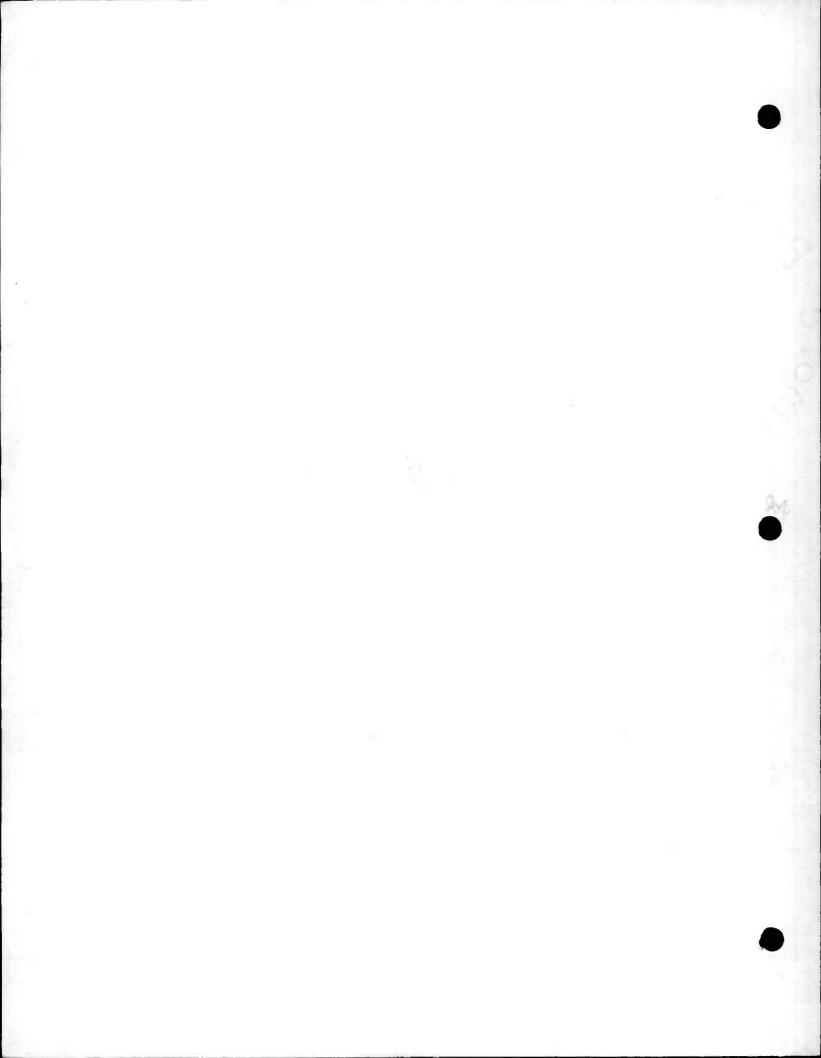
TO THE HOSPITAL DR ATENDING PHYSICIAN: The law requires that the death certificate be executed within a flow after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760



TO BE COMPLETED BY FUNERAL DIRECTOR

BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

2

					90	13410	
1 - FOR STATE OF I	MARYLAND / DEPAR CERTIF	RTMENT OF H		MENTAL HYGIEN	E		
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH	
Janet W.	Be11			April 20	1 0 0 5	10:30 P.M	
4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		RTHPLACE (State or Foreign	
220-44-6936 1 D M 2 2X F	96 YRS.	MONTHS DAYS	HOURS MIN.	June 12,	Co	Washington	
9e. FACILITY NAME (If not institution, give street end number)	Nursing	9b. CITY, TOWN C	R LOCATION OF DE	ATH	9c. COUNTY O	F DEATH	
Shady Grove Adventist	Center	Rock	ville		Mont	gomery	
RESIDENCE OF DECEDENT					Hone	gomery	
Maryland Montgome:		ermanto				10d. INSIDE CITY LIMITS? 1 YES 2 XNO	
10e. STREET AND NUMBER		101	ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?	
22100 Ridge Road	20876			S.A.			
11. MARITAL STATUS  12. WAS DECEDENT FORCES?  1 Never Married 2 Married FORCES?	T EVER IN U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Specify Yee n, Puarto Rican, atc.)	or No- 14. R.	ACE — American Indian, lack, White, etc.	
	WAR OR DATES		XNO Specify			white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed)	18e. DECEDENT'S (Give kind of life. Do NOT u.	Work done during mo	N st of working	186. KIND OF BUS	INESS/INDUSTRY	1	
Elementary/Secondary (0-12) College (1-4 or 5	+)	maker		Own h	ome.		
17. FATHER'S NAME (First, Middle, Last) William A. Willia	nson.		18. MOTHER'S NA	ME (First, Middle, Maiden		orsey	
19a. INFORMANT'S NAME (Type/Print)		ADDRESS (Street o		Poute Number, City or Town		_	
Garrison W. Bell	306	Chestn	ut Ave	nue, Wash	ingto	n Grove, Md	
20b. PLACE AND DATE OF DISPOSITION   20b. PLACE AND DATE OF DISPOSITION (Name of campelory, cromation 5   Other (Specify)   Torest Oak Cemetery   4/24 Gaithersburg. Md.							
22. NAME AND ADDRESS OF FACILITY Olin I. Molesworth.P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland							
23. PART i. Enter the diseases, or complications the	t caused the death. Do	not enter the mo	da of dving, auci	h as cardiac or reani	ratory arrest	Approximate	
snock, or neart failure. List only one cau	iae on aach line.		,		,,	interval Between	
IMMEDIATE CAUSE (Final disease or condition		•				Onaat and Death	
resulting in death)	neumon					1. week	
DUE TO	(OR AS A CONSEQUENCE O	F):	11		1		
Samuella Hat and distance to Arlex	is Sclerotion (OR AS A CONSCOUENCE OF 10 Sclerotion	Elereh	rallas	Eculas 1	Hiseas	38	
Sequantially list conditions, if any, leading to immediate	(OR AS A CONSEQUENCE O	F):		. 1			
CAUSE. Enter UNDERLYING	iosclerota	& Card	in Vastu	Ilm Dise	ase		
CAUSE (Disease or injury that initiated events DUE TO	(OR AS A CONSEQUENCE OF	F):		i City			
resulting in death) LAST							
PART II. Other aignificant conditions contributing to	death but not reaulting	in the underlying	cause given in	Part i. 24a. WAS AN A		4b. WERE AUTOPSY FINDINGS	
Dementia, Atriai	Februala	led		1 YES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
Ostenarlheites Ga	trape and.	oseal	Relle	~   '   '   '		OF DEATH?	
DID TOBACCO USE CONTRIBUTE TO CA			LINCEDTAIN	~_		1 TES 2 NO	
25. WAS CASE REFERRED TO MEDICAL	28. PLACE OF DEAT		UNCERTAIN	4 L			
EXAMINER? HOSPITAL:		OTHER:					
	ER/Outpatient 3 DOA	4 Nursing Home		8 Other (Specify)			
27. MANNER OF DEATH  1 Natural 5 Pending (Month, D		JURY WOI	JRY AT RK? ES 2 NO	28d. DEŞCRIBE HOW IN	JURY OCCURED		
3 Suicide 8 Could not be 28e. PLACE 0	F INJURY — At home, term, a			28t. LOCATION (Street of City or Town, State)	nd Number or Run	al Route Number,	
(Check only one)	my knowledge, daeth occurre	ed at the time, date	end place, end due	to the ceuse(e) end man	ner se stated.		

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Christopher M. 2901 Olney-Sandy Spring Rd., Olney, Schemm, M.D.,

29c. LICENSE NUMBER

366

CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, date end place, end due to the ceuse(e) end manner as stated. On the beele of examination end/or investigation, in my opinion, death occurred at the time,

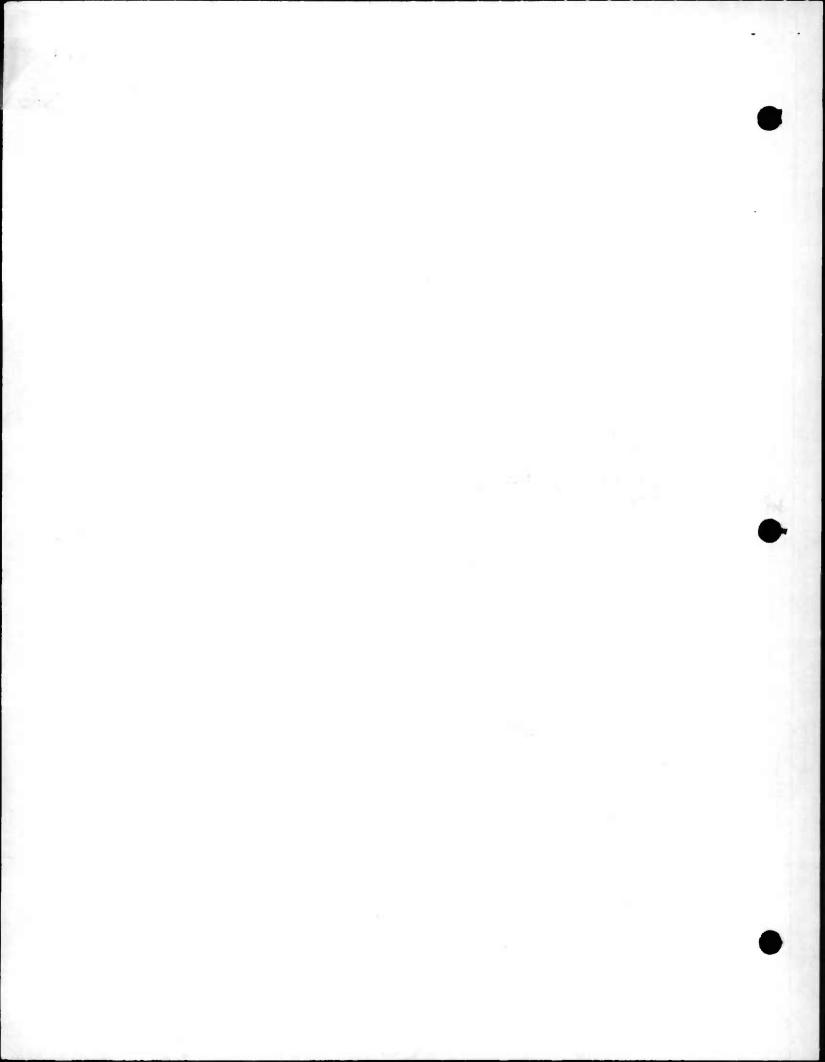
31. DATE FILED (Month, Day, Veer)
APR 2 4

32. REGISTRARIS SIGNATURE
Film Dhucker Reveals

29d. DATE SIGNED (Month, Day, Year)

▶April 21,1995

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF I	HEALTH AND	MENTA	L HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATH	VEAD	3. TIME OF DEATH
	Raleigh B.	Bolli	ng Sr.			Ap	ril 20,19	95	11:45 A M
	230-12-4939	1 RM 2 □ F 74	(In yrs. last birthday) YRS.	F UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE (Monti Apr.	27,1920		HPLACE (State or Foreign try)
TOR	90. FACILITY NAME (If not institution, give Frederick Memoria RESIDENCE OF DECEDENT				or Location of D erick	EATH		Frede	erick
DIRECTOR	10e. STATE 10b. COUNT	rederick		y, town or local					10d. INSIDE CITY LIMITS? 1 YES 2 XX
ERAL	100. STREET AND NUMBER 6528 Morningside	e Ct.		to	21769			S.A.	WHAT COUNTRY?
BY FUNER	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, OIVE WAR OR D	2 NO	If yes, sp	CENDENT OF HISPA pecify Cuben, Mexico 8 1 NO Speci	en, Puerto I	? (Specify Yes or No— Rican, atc.)	Blec	E — American Indian, k, White, etc.
ETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)	JCATION e completed) College (1-4 or 5+)		USUAL OCCUPATI work done during me se retired.)		16b	KIND OF BUSINESS/II	I .	
Once. COMPLET		1	securit	y office	er	е	lectric u	tilit	y co.
m 6	17. FATHER'S NAME (First, Middle, Last) Alvin Bolling						Middle, Maiden Surname) Bolling		
TO BI	Ollie M. Bolling		19b. MAILING 6528 M	ADDRESS (Street lornings:	end Number or Rural ide Ct.,	Midd	per, City or Town, State, 2 lletown, M	d. 2	21769
TS I	20e. METHOD OF DISPOSITION 1 Partiel 2 Cremetion 3 Ren a Donation S Cother (Specify)	noval from State	PLACE AND DATE Of the letery, crematory or of the letery.	of Disposition (Nather place)	ery	4/24			
eraminer	21. SIGNATURE OF HUNERAL SERVICE L	noxfa		Dona. 31 E	. Main S	ompso	n Funeral Liddletown	, Md.	
event, the medical	23. PART I: Enter the disease, or ahock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	CERBI	20 VA SC	cuch,			liac or raspiratory a	rreat,	Approximate Interval Between Onset and Death Hours
	Sequentially list conditions,	HYPER		N					Years
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A DIA BE 7	CONSEQUENCE OF		TUS				
ERTI	that initiated eventa resulting in death) LAST	d	CONSEQUENCE OF	-): 					
AL S	PART II. Other algnificant condition  Fre YELLAL A	na contributing to deeth b	ut not resulting i	n the underlyin	g ceuse given in	Part I.	24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 100	24b	. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
AN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL		F DEATH YE			N 🗆			1 YES 2 NO
SICI/	1 TYES 2 NO	HOSPITAL:		OTHER:	ne 5 🗆 Residence	6 □ Other	(Spanihi)		
BY PHY	27. MANNER OF DEATH  1 Heturel 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b, TIME	E OF 28c. INJ			CRIBE HOW INJURY OF	CURED	
TED 18	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, atc. (Spec	— At home, farm, s	treet, factory, offic	•	28f. LOCA City o	ATION (Street and Number Town, State)	or or Rural F	Route Number,
45   1		ICIAN: To the best of my knowled: On the basis of examination							) end menner ee stated.
B B	29b. SIGNATURE AND TITLE OF CERTIFIE				29c. LICENSE NUI	MBER	29d. DA	TE SIGNED	(Month Day Year)
2	30. NAME AND ADDRESS OF PERSON WE		ATH (ITEM 27) (Type,	Print) TOLL	HOUSE	AVE	FRED.	ERIC	ill
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN							

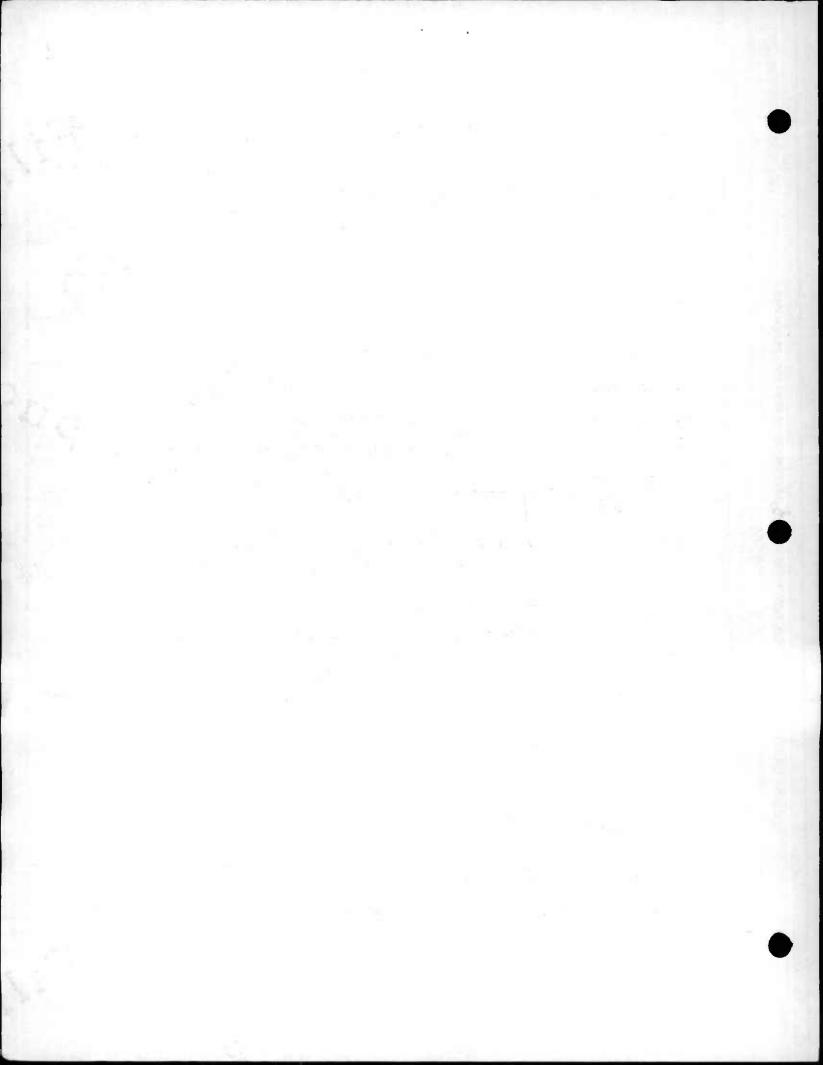


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APR 2 7 1995

	1 - STATE OF STATE OF	MARYLAND / DEPAR CERTIF	TMENT OF HI	EALTH AND I	MENTAL HYGIE REG. N		
	1. OECEDENT'S NAME (First, Middle, Leet)  Curchtopher D.  4. SOCIAL SECURITY NUMBER 5. SEX	Bartel	2		2. DATE OF DEATH MONTH  7. PATE OF BIRTY	17 9	
	216-02-2035 1 ⅓M 2 □ F	6. AGE (In yrs. last birthday)  18 YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	Oct. 17,	1976	BIRTHPLACE (State or Foreign Country) Nash., D.C.
DIRECTOR	96. FACILITY NAME (If not Institution, give street and number) Mt. Washington Pediatric RESIDENCE OF DECEDENT			ore City		9c. COUNTY	·
	Maryland Prince Georg		Laurel		a l		10d. INSIGE CITY LIMITS? 1 YES 2 X NO
FUNERAL	100. STREET AND NUMBER 8201 Joshua Court		101.	20708	7		S.A.
B	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDE FORCES? IF YES, GIVE	13. WAS DECE If yes, spe 1 — YES	RACE — American Indian, Black, White, etc. Specify: White				
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  Grade 6  College (1-4 or 5	(Give kind of	USUAL OCCUPATION work done during mos se retired.)	N t of working		ide scho	
CO	17. FATNER'S NAME (First, Middle, Last)  J. Mark Bartel				ME (First, Middle, Meid a Glass	en Sumeme)	
) BE	19e. INFORMANT'S NAME (Type/Print)	19b. MAILING	ADDRESS (Street ar		Route Number, City or T	own, State, Zip Co	de)
5	J. Mark Bartel	8201	. Joshua	Court I	aurel, Mo		
	20a_METHOD OF DISPOSITION  YABuriel 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	20b. PLACE OF DISPO				location — city aurel,	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		Dona		neral Hom	ne P.A.	arvland 20707
	23. PART I. Enter the (beeses, or complications the abook, or heart feliure. List only one commendation in the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the comment of the	et caused the deeth. Do use on eech ilne.					
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	o gon as a constituence of the stands a consequence of the stands	sirde	astric	Repl	سيد	Conzenta
PHYSICIAN: MEDICAL CI	PART II. Other algorificant conditions contributing to Serve Cerebral relaudation	o death but not resulting	W the underlying	cause given in	PERF	AN AUTOPSY FORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 UYES 2 10 MO
YSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 VES 2 1 M9  1 L Mightlent 2	☐ ER/Outpatient 3 ☐ DOA	OTHER:	ACE OF DEATN (C)	neck only one)  8  Other (Specify)		
ВУ РН	14 Natural 5 Pending 2 Accident Investigation	Day, Year)	M 1 V	RK? 'ES 2 NO	28d. DEŞCRIBE NO		
ETED	3 Suicide 6 Could not be 4 Homicide determined	OF INJURY — A1 home, farm, g, atc. (Specify)	, street, factory, office		28f. LOCATION (Stre City or Town, Str		Hursi Houte Number,
COMPLI	29e. CERTIFIER (Check only one)  1 CERTIFYING PNYSICIAN: To the best of MEDICAL EXAMINER: On the basic of						and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s
TO BE	POPULATION OF CHATTER AND ATTIVE OF CHATTER AND ADDRESS OF PERSON WHO COMPLETED CA	USE OF DEATH (ITEM 27 /5	Drint)	29c. LICENSE NU D 4-65	MBER 7	≥ A P	SIGNED (Month, Day, Year) WILL 19 1995

MTWASHINGTON REDIATRIC HOSP.



BALTIMORE, MARYLAND 21215-0020

The law

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO 1. DECEOENT'S NAME (First, Middle, Last) DATE OF DEATH 3. TIME OF DEATH 2 30 Della B. 01/15 A SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR IF UNDER 24 HE DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign 1 - M 2 X F 235-06-9535 1916 West April Virgini 17 Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF GEATH DIRECTOR Prince George Accokeek 17615 Clinton Drive 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Prince George Accokeek Maryland 1 TES 2 XX permit. 10a. STREET AND NUMBER FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? after druth. Page 6 may be retained by the hospital or attending physician. 20607 17615 Clinton Drive U.S.A. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 24 THO IF YES, GIVE WAR OR OATES 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 A0 Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married В 3 Wildowed 4 Divorced White 60 15. OECEDENT'S EOUCATION 16e. DECEOENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INOUSTRY (Specify only highe H Elementary/Secondary (0-12) College (1-4 or 5 +) COMPI 8 Homemaker Her Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ Charlie Birchfield BE Laura Hawkins notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Same as #10 Jerry Priddy Pe 20s METHOD OF DISPOSITION

1 Ouriel 2 Cremation 3 Ram 20b. PLACEAND DATE OF DISPOSITION (APSY 1119, 1995 20c. LOCATION - City or Town, State must White Chapel Mem Gardens 4 Donetion 5 Other (Specify) Barbourville, W Va. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Williams Funeral Home, P.A. M00668 Rt. 225 & Glymont Rd., Indian Head, Md 421 medical es, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory street, the attending physician and completely filled in the Mental Hygiene prior to burial, cremation, or mines 23. PART I. Enter the dige shock or heart failure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final Onset and Dasth the disease or condition antenopelerote dander vas culor discore resulting in death) traumatic event. CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF) cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 6 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY Health and N PERFORMEO? 1 TYES 2 LENT OF DEATH? 1 YES 2 NO has been s Dept. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WOLLD VINCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 PES 2 NO 26. PLACE OF DEATH (Check only one) r this certificate h item HOSPITAL OTHER: OR ATTENDING PHYSICIAN: 1 Inpetiant 2 ER/Outpetient 3 DOA ng Home 5 Healdenca 6 - Other (Specily) 0 27. MANNER OF DEATH 26s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT marked, 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO DIRECTOR: After the hours after death v ВҰ Investigation 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) .00 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 200 4 Homicide item 29a. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the filme, date and place, and due to the cause(a) and manner as stated. THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 h TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 M 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(a) and manner as stated. 201. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER I. OATE SIGNED (Month, Day, Year) BE 5 32. REMISTRARIS SIGNATURE Pulsa di Auditor Ravialle APR 2

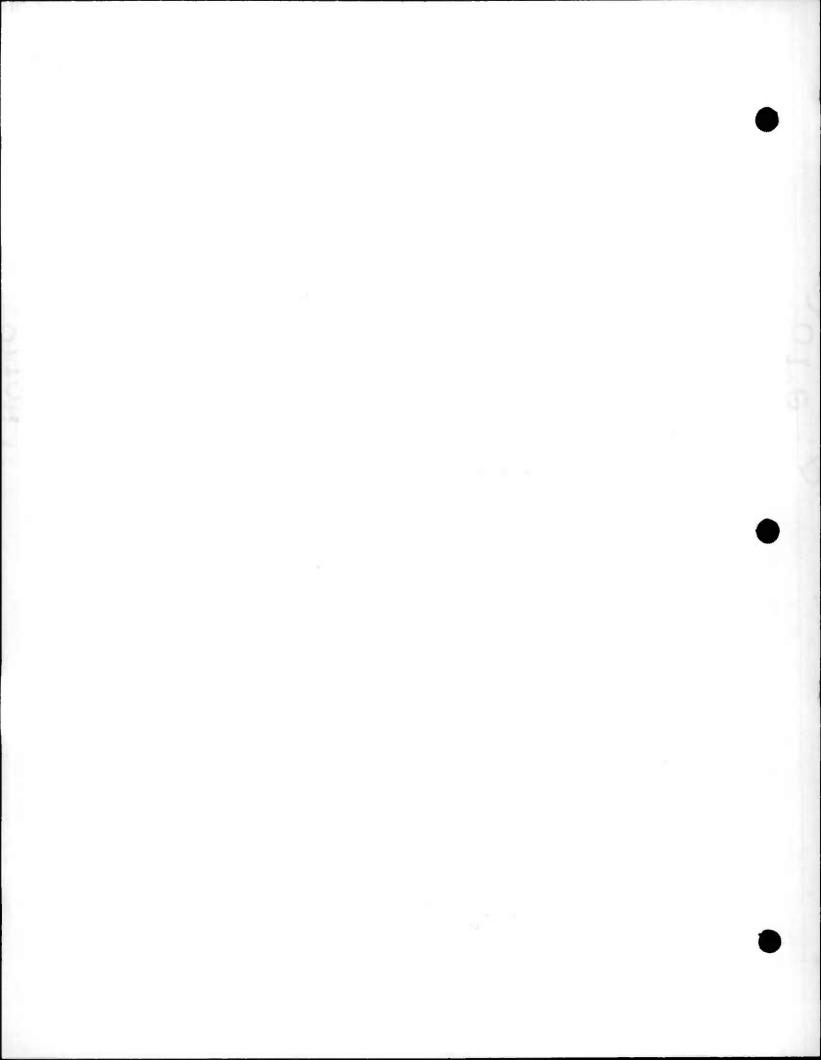
BALTIMORE, MARYLAND 21215-0	AN. The law requires that the death certificate be executed within a rount after death. Page 6 may be retained by the hospital or attending
	b
DIVISION OF VITAL RECORDS, P.O. BOX 68760	ath certificate be executed within
RECORDS,	requires that the de-
OF VITAL	HYSICIAN; The law
DIVISION	L OR ATTENDING PHYSICIAN

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the found retained to the hospital or attending physician.

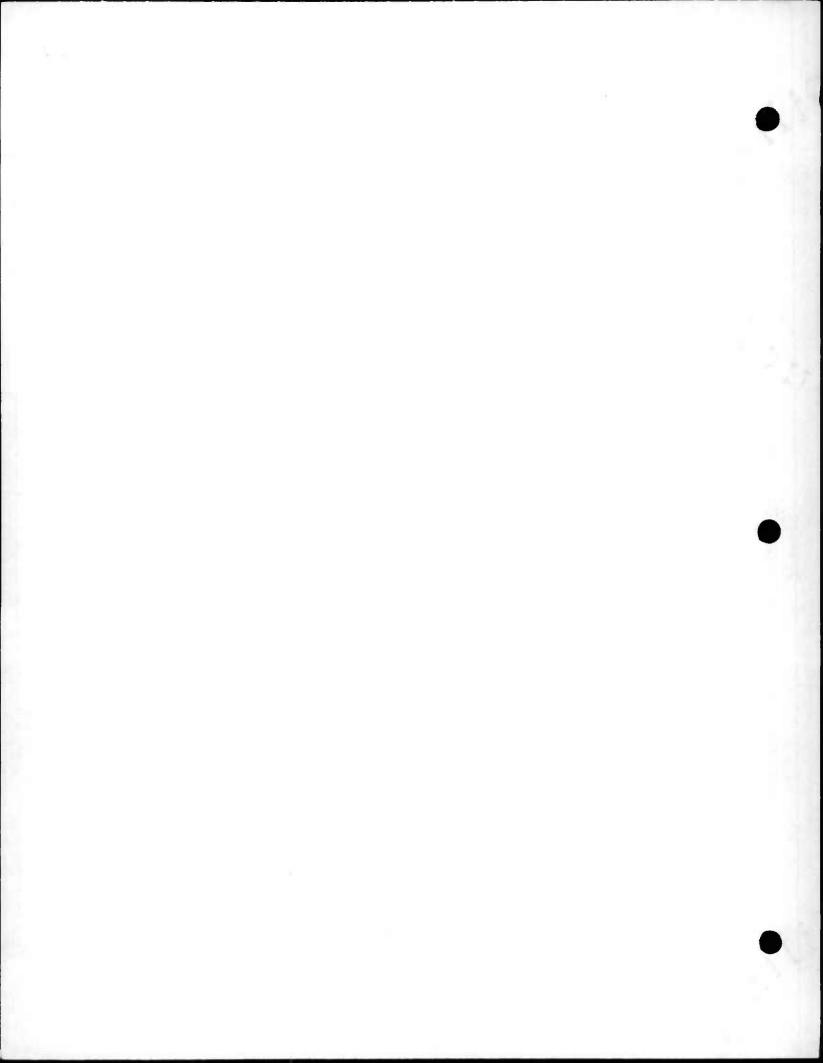
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT	OF H	EALTH /	AND MEI	TAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)						2.	DATE OF DEATH			3. TIME OF DEATH	1
	REBA IDELLA	BUSER					A	pril 1	4, 199	95	2:44	Ам
			n yrs. leat birthday)	IF UNDER	1 YEAR	IF UNDER 2	14 HRS. 7. 1	Month Day Year		8. BIRTH Count	IPLACE (State or Fore	ign
		□ M 2 X F 85	YRS.	MONTHS	LAYS	HOURS	AP	Month, Day, Year) RIL 3 19	10	Oourn	" PA.	
ac I	9e. FACILITY NAME (If not institution, give atree MEMORIAL HOSPITAL	t end number)				LAND	N OF DEATH		9c. COUN	TY OF D	EATH	
5	RESIDENCE OF DECEDENT			001	IDLIK.	LIMD			ALLE	GAN	Y	
DIRECTOR	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN C	OR LOCAT	ION					10d. INSIDE CITY	
		EGANY		CUMBI	ERLA	ND					1 YES 2 N	10
RAI	10e. STREET AND NUMBER					ZIP CODE					WHAT COUNTRY?	
FUNERAL	908 YALE STREET	MARITAL STATUS										
日日	1 Never Married 2 Married	2. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	1 1	If yes, spe	ecify Cuben,	, Mexicen, Pu	RIGIN? (Specify Ye erto Rican, etc.)	e or No-	14. RACI Bleci	E — Americen Indien k, White, atc.	,
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	TES		1 [] YES	2 NO	Specify:		1	Speci	"y: WHITE	
윤	18. DECEDENT'S EDUCATION (Specify only highest grade completed)  Elementary/Secondary (0-12)  8  18- DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSE KEEPER  17. FATHER'S NAME (First, Middle, Last)  18- DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  HOUSE KEEPER  18. MOTHER'S NAME (First, Middle, Maiden Surname)											
9		College (1-4 or 8+)	Ille. Do NOT us	se retired.)		at or working				_		
ĕ.	8 17. FATHER'S NAME (First, Middle, Last)		HOUSE K	EEPE	Κ.			HOUSE		R		
0	HENRY CLAY FETT	repe					ER'S NAME (F E DIC)	First, Middle, Maiden ZENT	Surname)			
BE	19a. INFORMANT'S NAME (Type/Print)	LEKS	19h MAH INC	ADDRESS	(Street o			Number, City or Tox	- 00 + 70	0.4.		
2	JOYCE E. BUSER							INGS, W.			ı	
1	200 METHOD OF DISPOSITION	20b.	PLACEANDDATE	OF DISPOS	ITION /Na	ma of		DATE 20c, LC	CATION — C	ity or To	wn. State	
	1 Surial 2 Cremation 3 Remova 4 Donation 8 Other (Specify)	r from StateHI	LCREST	CEME 1	CERY	APRI	L 17	1995 CUM	BERLA	ND N	ARYLAND	
	21. SIGNATURE OF FUNERAL SERVICE-LICENSIDE  22. NAME AND ADDRESS OF FACILITY  MERRITT-ADAMS FUNERAL HOME											
	Dale J. 1	end						EET CUME		D MA	ARYLAND	
	23. PART I. Enter the disessas, or con shock, or heart failure. Lis	pilcetions that caused	the deeth. Do r								Approximat	
	IMMEDIATE CAUSE (Finel	t only one cease on ee	cri line.								Onset and I	
	disesse or condition resulting in death) e	ACUTE MYO	CARDIAL	INFA	ARCT	ION					10 DAYS	, [
		DUE TO (OR AS A	CONSEQUENCE OF	F):								
CERTIFICATION	Sequentially list conditions, b	DUE TO (OR AS A	CONSEQUENCE OF	FI:								
\¥	If any, leading to immediate cause. Enter UNDERLYING			,								
Ĕ	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	F):								
EH	resulting in death) LAST											
	PART II. Other significent conditions of	ontributing to deeth bu	it not resulting i	In the un	deriving	cause giv	ven in Part	I. 24e, WAS AN	AUTOPSY	24b	WERE AUTOPSY FINE	DINGS
MEDICAL					,			PERFO	RMED?	1	AVAILABLE PRIOR TO	
		1						1 TYES 2	NO NO		OF DEATH?	
ä	DID TOBACCO USE CONTRIB	SUTE TO CAUSE OF	DEATH YE	S 🗆 N	NO M	UNCE	RTAIN [	3			1   123 2   MC	´
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	8. PLACE OF DEAT									
YSI	1 YES 2 NO	Inpetient 2 - ER/Outpe	tient 3 🗆 DOA	OTHER		5 🗆 Reel	dence 8 🗆	Other (Specify)				
	27. MANNER OF DEATH  1 Netural 5 Pending	(Month, Day, Year)	28b, TIM INJ	E OF URY	28c. INJU	RK?		DESCRIBE HOW	NJURY OCCI	JRED		
ВУ	2 Accident Investigation	28e. PLACE OF INJURY	44 5 2 2 4 2 2 2	M		ES 2 _						
	3 Suicide 8 Could not be 4 Homicide determined	building, atc. (Specif	y)	street, racti	огу, опісе		281.	LOCATION (Street City or Town, Stete)	and Number o	r Rural A	loute Number,	
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MP.		N: To the best of my knowle On the beels of examination									and manner as state	
	29b. SIGNATURE AND TITLE OF CERTIFIER	A						auto ona piace, or				
BE	Mul	_/(				D 14	4865		D 1	/	Month, Day, Year)	اسره
2	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEA	TH (ITEM 27) (Type,	Print)		D 1-	.005		L SY	1	17,199	13
	Robustiano Barrer	a M.D. Memo	rial Hos	spita	1 Me	dical	1 Bldg	. Cumbe	rland	MD	21502	
	31. DATE FILED APPROT 1995	32 REGISTANT'S SIGNA	Mardall									$\neg$



		1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPAI CERTIF	RTMENT OF	HEALTH AND	MENTAL HYG				
		1. DECEDENT'S NAME (First, Middle, L					2. DATE OF DEAT	DAY	YEAR 3. TIME OF DEATH		
		THELMA VIRO	INIA CARRO				April 2		95 4:00 a M		
		577-18-8661	The second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon	(In yrs. lest birthday) 75 YRS.	MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Ye Aug 23,		8. BIRTHPLACE (State or Foreign Country)		
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1, 2, 3 sh	CTOR	9915 Old Solom	ons Island Roa	ad	Owing	OR LOCATION OF E	PEATH		unty of Death lvert		
Pages	DIRE	MD Ca	lvert	10c. CI	Owing				10d. INSIDE CITY LIMITS? 1 YES 2 1 NO		
n. ansit permit.	VERAL	100. STREET AND NUMBER 9915 Old Solom	ons Island Roa	ad	10	H. ZIP CODE	0736	10g. CIT	USA		
21215-0020 al or attending physician. for use as the burial-transit	BY FUNI	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I	2 K NO	If yes, s	CENDENT OF HISPA pecify Cuban, Maxic 8 2 NO Speci	NIC ORIGIN? (Special an, Puarto Rican, sto fy:	fy Yes or No— c.)	14. RACE — American Indian, Black, White, atc. Specify: White		
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AND 21: the hospital or detached for u	COMPLET	Elementary/Secondary (0-12) 12	College (1-4 or 5+)	house w	ise retired.)	out of Working	own	home			
YLAN by the hose be detach at once.	8	17. FATHER'S NAME (First, Middle, Last				18. MOTHER'S N	AME (First, Middle, Mi	,			
MARYLAND retained by the hospit 5 should be detached notified at once.	H H	Clyde D. Suga	gs		-SALSSIANIA	Annie	Myrtle				
MAR retained 5 should notified	ο	Louise C. Owing	ns				Route Number, City of	v Town, State, Zi	p Code)		
		20e. METHOD OF DISPOSITION	20			S # 10 above  DISPOSITION (Name of DATE   20c. LOCATION — City or Town			Cibu or Town State		
2 0 0 0		1X Burial 2 Cremation 3 4 Donation 8 Other (Specify) 21. SIGNATURE OF FUNERAL, SERVICE	Removal from State	metery, cremetory or o D Vetera	ns Ceme	tery 4-	26-95		nham, MD		
death.		22. NAME AND ADDRESS OF FACILITY  Rausch Funeral Home, P.A., Owings, MD  23. PART I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate									
th certificate be executed within 24 nou ending physician and completely filled i Hygene prior to burial, cremation, or or other traumatic event, the more or other traumatic event, the more or other traumatic event, the more or other traumatic event, the more ending the more ending the more ending the more ending the more ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the ending the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the end the	RTIFICATION	shock, or heart felice IMMEDIATE CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	aUNC  DUE TO (OR AS-	A CONSEQUENCE O	) [ r): r):	ode or dying, aud	th sa cerdiac or s	respiratory ar	Approximate Interval Between Onset and Death		
TAL KECORDS, P. The law requires that the death sate has been signed by the attenvitate Dept, of Health and Mental H tem 23 shows any injury, or	MEDICAL CEI	PART II. Other aignificent condi		but not resuiting	in the underlyin	g cause given in	PE	S AN AUTOPSY REFORMED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO		
law re as bee bept. o	ä	DID TOBACCO USE CO		OF DEATH YE	ES LY NO [	UNCERTAI	N 🗆				
Certificate has the State Dept.	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICA EXAMINER?  1 YES 2 THO	HOSPITAL: 1   Inpetient 2   ER/Out	26. PLACE OF DEA	OTHER:		8 Other (Specify)	)			
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DING PHYS After this death with	⋒	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆	YES 2 NO					
TTEN TOR: after	8	3 Suicide 8 Could not determined		Y — At home, farm, orify)	street, factory, offic	•	281. LOCATION (St City or Town, S	treet and Number State)	r or Rural Route Number,		
TO THE HOSPITAL OR A TO THE FUNERAL DIRECT DE FIED WITHIN 72 hours IMPORTANT: If Item	COMPLET		HYSICIAN: To the best of my know						ted. he cause(a) and menner as stated.		
E FUN		29b. SIGNATURE AND TITLE OF CERT	IFIER			29c, LICENSE NU			'E SIGNED (Month, Day, Year)		
는 다음 <b>조</b>	) BE	Placellahan ty	on mo			04	74194		1-25-95		
7	10	36. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF DE		, Print)			,			
		31. DATE FILED (Mogth, Day, Year) APR 25 1	1995 32. REGISTRAR'S SIGN	YATURE RANGELL							



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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR		CERTIF	ICATE	PEATH	REG. NO	).	
		1. DECEDENT'S NAME (First, Middle, Last RAMONA	)		CORBIN			1995 YE	
		4. SOCIAL SECURITY NUMBER		E (In yrs. last birthday)	IF UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year)	0. 6	8:10P M MRTHPLACE (State or Foreign country)
9	-	218-48-8664		50 YRS.	MONTHS DAT	S HOURS MIN.	Feb 19,17	945	ma.
pinous	-	9a. FACILITY NAME (If not institution, give	street and number)		9b. CITY, TOW	N OR LOCATION OF D	EATH	9c. COUNTY	OF DEATH
2.3	ECTOR	THE JOHNS H	OPKINS HOSPI	TAL	BAI	TIMORE CI	TY		
es 1.		10a. STATE / 10b. COUN	ту	10c. CIT	Y, TOWN OR LO	CATION			10d. INSIDE CITY
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permit.	3AL	10. STREET AND NUMBER	1			101. ZIP CODE	/	10g. CITIZEN	OF WHAT COUNTRY?
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hysic urfal-	J.	11. MARITAL STATUS  1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 YE	ES 2 AND	If yes,	specify Cuban, Maxico		a or No- 14.	RACE — American Indian, Black, White, atc.
P 2 9	B	3 Widowed 4 Sivorced	IF YES, GIVE WAR OR	R DATES	10'	YES 2 7 NO Specif	fy:		Specify: Plank
	윤	15. DECEDENT'S ED (Specify only highest grad	UCATION de completed)	18e. DECEDENT'S	USUAL OCCUP.	ATION	18b. KINO OF BU	SINESS/INOUST	RY
17 a a	Ē	Elementary/Secondary (0-12)	College (1-4 or 5+)	Me. Do NOT u	se retired.)	1	7.	mesti.	
AND 2 he hospital detached to	once.	17. FATHER'S NAME (First, Middle, Last)		1	Jomest.				_
YLA by the be det	-	Menill M	rem's				AME (First, Middle, Malden	Sumame)	
E 8 3	B 2	19a. INFORMANT'S NAME (Type/Print)	11/1-3	19b. MAILING	ADDRESS (Stre	AVAII	Route Number, City or Tow	in State 7in Cod	2) /
≥ 5 m		Tyron Corpi	V	304	€.	/ / /	Ane F	with	d. 21826
E 2	must be	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Res	movel from State	20b. PLACE AND DATE	OF DISPOSITION		DATE 20c. LO	CATION City	or Town, State
Page 6 mi		4 Donation 6 Other (Specify)		GECCO A		methry	4/19 01	7/is bury	md. 21801
th. P	examiner	21. SIGNATURE OF FUNERAL SERVICES	Centre		22. NAME	WIS No	WATSON F	UNER	se Home
2 9 mi		$\sim$ $\wedge$	X_			& West	Rd. Sol	sbury.	md. 21801
urs in t	medica	23. PART I. Entar tha diseases, or shock, or haert fallura	complications that cause. List only one cause on	sed the daeth. Do i	not anter tha	mode of dying, suc	h as cardiac or resp	iratory arrest,	Approximata interval Between
filled on, or	9	IMMEDIATE CAUSE (Final disease or condition	/	/					Onset and Death
rithin letely remati	f.	resulting in death)	s. <u>H</u>	S A CONSEQUENCE O	mia				30 min
	e event,	_	DUE TO (ON AS	S A CONSEQUENCE O	F):				/
executed n and con to bunal,	or other traumatic	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	S A CONSEQUENCE O	F):				
ate be sysician prior	S E	cause. Enter UNDERLYING CAUSE (Disease or injury	G						
certificate ding physical principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the principle of the princip	ag E	that initiated events resulting in desth) LAST	DUE TO (OR AS	S A CONSEQUENCE O	F):				
J 6 8 -	CER 9	Todaling in documents	d						
3 4 5	3	PART II. Other eignificent condition	ne contributing to deeth	but not resulting	in the underly	Ing ceuse given in			246. WERE AUTOPSY FINDINGS
a de de de de de de de de de de de de de	일	Diabete	E, HYD	enteus,	104		PERFOR	,	AVAILABLE PRIOR TO COMPLETION DF CAUSE
11 3 "-	8 8								DF DEATH?
	Z3 sh	DID TOBACCO USE CON	TRIBUTE TO CAUSE	OF DEATH Y	S NO	☐ UNCERTAI	NØ		
	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF OEA	TH (Check only o	ne)			
SICIAN: The certificate h	I S	1 TYES 2 NO	1 Inpatient 2 ER/Ou		4 🗆 Nursing H	ome 5 🗆 Residence			
돌를 출 C	marked, or BY PHY	27. MANNER OF DEATH  1 Natural 5 Pending	28s. DATE OF INJURY (Month, Day, Year,		JURY	INJURY AT WORK? YES 2 NO	28d. OEŞCRIBE HOW I	NJURY OCCURE	0
OR ATTENDING DIRECTOR: After hours after death		2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJU	RY — At home, farm,	' [		28f. LOCATION (Street )	and Number or Bi	iral Bruta Number
OR ATTENDING DIRECTOR: After hours after death	∞ Ш	4 Homicide 8 Could not be determined	building, atc. (Sp	pecify)			City or Town, State)	ino rumber or re	rai node Nambel,
	E E	29a. CERTIFIER 1 CERTIFYING PHY	SICIAN: To the best of my kno	owledge death occur	ad at the time of	iste and place, and due	to the enuerial and man		
경투 분	= =		IER: On the basis of examinat						se(s) and manner as stated.
E FUN	E O	29b. SIGNATURE AND TITLE OF CERTIFIC				29c. LICENSE NUI			NED (Month, Day, Year)
TO THE HOSPIT TO THE FUNERA be filed within 7	MPOR O BE	awak	Gull	MD		762428	39/	D 4-	14-95
2	<b>≧</b>   ₽	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF	OEATH (ITEM 27) (Type	, Print)	/ 0	/		
		DR. MARK GRUB		WOLFE STR	EET BA	LTIMORE .	MARYLAND	21287	7
		APR 1 8 199	32 HEGISTHAR'S SIG	GNATURO LOS RANGELLA					
2		71.11 1 0 100.	, //						

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RALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a flours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - STATE REGISTRAR	STATE OF MARYL			F HEALTH AND	MENTA	AL HYGIENI REG. NO.	E		
1. DECEDENT'S NAME (First, Middle, Last)			1			E OF DEATH			3. TIME OF OEATH
ETHEL K		(	anti	vel/	APR			95	0730 M
4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YE			E OF BIRTH		8. BIRTH	IPLACE (State or Foreign
152-20-2759	1 M 2 F	86 YRS.	MONTHS DA	YS HOURS MIN.		ruary 9,	1909		ew York
9a. FACILITY NAME (If not institution, give st				WN OR LOCATION OF D	DEATH		9c. COU	NTY OF D	DEATH
PENINSULA REGIONA	AL MEDICAL C	ENTER		SALISBURY			W	ICOM	ICO
10e. STATE 10b. COUNTY		10c, CITY	r, TOWN OR LO	OCATION					10d. INSIDE CITY
Maryland Wic	omico		Salis	bury					LIMITS?
10e. STREET AND NUMBER				10f, ZIP CODE			10g. CITI	ZEN OF A	WNAT COUNTRY?
911 Roger St.				21801				USA	
11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS	DECENDENT OF HISPA	NIC ORIGI	IN? (Specify Yes	or No-	14. RACI	E — American Indian,
1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR D			i, specify Cuben, Mexic YES 2 ⊠ NO Speci		Rican, etc.)	ĺ	Speci	k, White, etc.
2023 III 2023 III								Wh	ite
15. DECEDENT'S EDUC (Specify only highest grade	completed)	18a. DECEDENT'S (Give kind of w	OSUAL OCCUP	PATION g most of working	16	b. KIND OF BUS	INESS/IND	USTRY	
Elementery/Secondary (0-12)	College (1-4 or 5+)	Cafeteri				Public	Scho	01	
17. FATHER'S NAME (First, Middle, Last)		- Garceer	d decen	18. MOTHER'S NA				-	
John	St.John			Grace	AME (F#36,		Love	11	
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Str	eet and Number or Rural	Route Nun	nber. City or Town	State Zin	Gode)	
Grover Cantwell	Sr.			St., Sal					
20s. METHOD OF DISPOSITION	200	. PLACE AND DATE O	F DISPOSITION			TE 20c. LOC	_		wn, Stata
1X Buriat 2 Cremation 3 Ramo		netery, crematory or ot	herplece) emoria	1 Park	1	17 Sa			
21. SIGNATURE OF FUNERAL SERVICE LICE			22. NAM	E AND ADDRESS DF FA	ACILITY			) ,	
1 / LAN	10060.0	111		olloway Fu					VD 01001
23. PART/1. Enter the diseases, or co	omplications that cause	d Da deeth Do o	of enter the	01 Snow H	1 I I I	Kd., Sa	lisb	ury,	
anock, or neert fellure. L	ist Drily one cause on e	each line.	or enter the	mode of dying, suc	Cii as car	disc or respir	atory arr	est,	Approximats intervel Between
IMMEDIATE CAUSE (Final disease or condition	R(1		anda.	12 /					Onset and Deeth
resulting in deeth)	DUE TO (DR AS	A CONSEQUENCE OF	1:	MONIA					80Ays
	Some	20 C	200	1					
Sequentially liet conditione, If any, leading to immediate	DUE TO (OR AS	CONSEQUENCE OF	):						
CAUSE (Discess or injury									
that initiated events	DUE TO (OR AS	CONSEQUENCE OF	):						
resulting in death) LAST	·								
PART II. Other significent conditions	contributing to deeth b	out not resulting in	n the underl	ving ceuse given in	Part i	24a. WAS AN A	MITOPSY	245	. WERE AUTOPSY FINDINGS
		line		yg cours given in		PERFORI	WED?	240	AVAILABLE PRIOR TO COMPLETION OF CAUSE
					_	1 TYES 2	NO		OF DEATH?
DID TOBACCO USE CONTR	IRLITE TO CALISE O	E DEATH VE	CI NO	☐ UNCERTAI	NI				1 TYES 2 NO
25. WAS CASE REFERRED TO MEDICAL	IBOTE TO CAUSE O	26. PLACE OF DEAT			N Z				
EXAMINER?	HOSPITAL: 1/ Inpatient 2 ER/Outs		OTHER:	Home 5 - Residence	- O OW				
27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME	OF 28c.	INJURY AT		SCRIBE HOW IN	JURY OCC	URED	
1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU		WORK?					
3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Spec	— At home, ferm, s	lreet, factory, o	office	28f. LO	CATION (Street ar	nd Number	or Rural F	Route Number,
4 Homicide determined	bulleting, etc. (Spec	City)			City	or Town, State)			
29a. CERTIFIER (Check only 1 CERTIFYING PHYSIC	IAN: To the best of my know	ledge, death occurre	d at the time.	late and place, and due	to the ce	use(s) and man	nor on what	ad .	
	: Dn the basis of axaminatio								) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI					(Month, Day, Year)
Tun	an			0398				- 4	(95
30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Print)	30,0	-			1114	
M ATKIN			Chus	An Presso	5	elis mi	7	180	,
31. DATE FILED (MORT DRY, Year)	32. BEGISTRAR'S SIGN		0 100	- James	21.	-9 7-12			,
HLK T 0 1995	Java d'avels	ortandall							

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, P.O. BOX 68760, OR ATTENDING PHYSICIAN:

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29b. SIGNATURE AND TITLE OF CERTIFIER

APR 26 1995

31. DATE FILED (Month, Day, Year)

w

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Bennett M.D.

32: REGISTRAR'S SIGNATURE

FUNERAL I HOSPITAL

Pages 1, 2, 3 should

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF GEATH Bertha Gower April 25, 1995 150 P Cherry 4. SOCIAL SECURITY NUMBER 5 SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 189 16 8723 "New York 72 DAYS HOURS J"taty" "" 1922 1 M 2 X F YRS 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 4040 Robinson Road Huntingtown Calvert RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Calvert HUntingtown 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10a. CITIZEN OF WHAT COUNTRY? 4040 Robinson Road 20639 UNited States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Maxicen, Puarto Ricen, etc.)

1 YES 2 NO Specify: 14. RACE — American Indien, Bleck, White, etc. 1 Never Merried 2 Merried Specify: white ₽ 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) Elementary/Secondary (0-12) 12 housewife homemaker 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) 7 Joseph J. Gower Edna Hall BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Stephen E. Cherry 4040 Robinson Rd. Huntingtown Maryland 2063 å 20s. METHOD OF DISPOSITION
1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of pril 26 Metropolitan Crematory DATE 1 28c LOCATION - City or Town, State must 4 Donation 5 Other (Specify) Alexandria Virginia 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rausch Funeral HOme 4405 Broomes Is. Rd. Port Republic MD medicai 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, Approximete ehock, or heert feilure. Liet only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Finel **Oneat and Death** ě diseese or condition_ heart failure angestive Zuears resulting in deeth) DUE TO OR AS A CONSEQUENCE OF). CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in desth) LAST PART ii. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL COMPLETION OF CAUSE 1 - YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🗖 PHYSICIAN: UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one HOSPITAL: OTHER 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 28 is marked, Natural 5 Pending 1 YES 2 NO BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, ferm, atreet, factory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Homicide Item 29e. CERTIFIER TE CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(e) end menner ee stated. Ξ 2 MEDICAL EXAMINER: On the bests of examination end/or investigation, in my opinion, death occurred at the time, data end placa, end due to the ceuse(e) end menner ee stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7.

Charles W. Bennett, M.D. 11845 H.G. Trueman Rd. Lusby, Maryland

29c. LICENSE NUMBER

25156



1995

29d. DATE SIGNED (Month, Day, Year)

April26.

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DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 frouts after death. Page 6 may be retained by the hospital or attending physician.	for use as the burial-transit		tem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
retained by the hospi	5 should be detached		notified at once.
leath. Page 6 may be	funeral director, page		xaminer must be
things hours after o	etely filled in by the	emation, or removal.	nt, the medical e
icate be executed wi	ohysician and compli	e prior to burial, cre	er traumatic ever
that the death certif	ed by the attending	h and Mental Hygier	any Injury, or oth
N: The law requires	ficate has been signe	State Dept. of Healt	Item 23 shows
TENDING PHYSICIA	TOR: After this certif	after death with the	28 is marked, or
DR AT	DIRECT	NOUIS &	fem 2

CERTIFICATION

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S BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

HOSPITAL I FUNERAL I WITHIN 72 h TO THE HOSPITA
TO THE FUNERAL
De filed within 72
IMPORTANT: II

Item

Pages 1, 2, 3 should

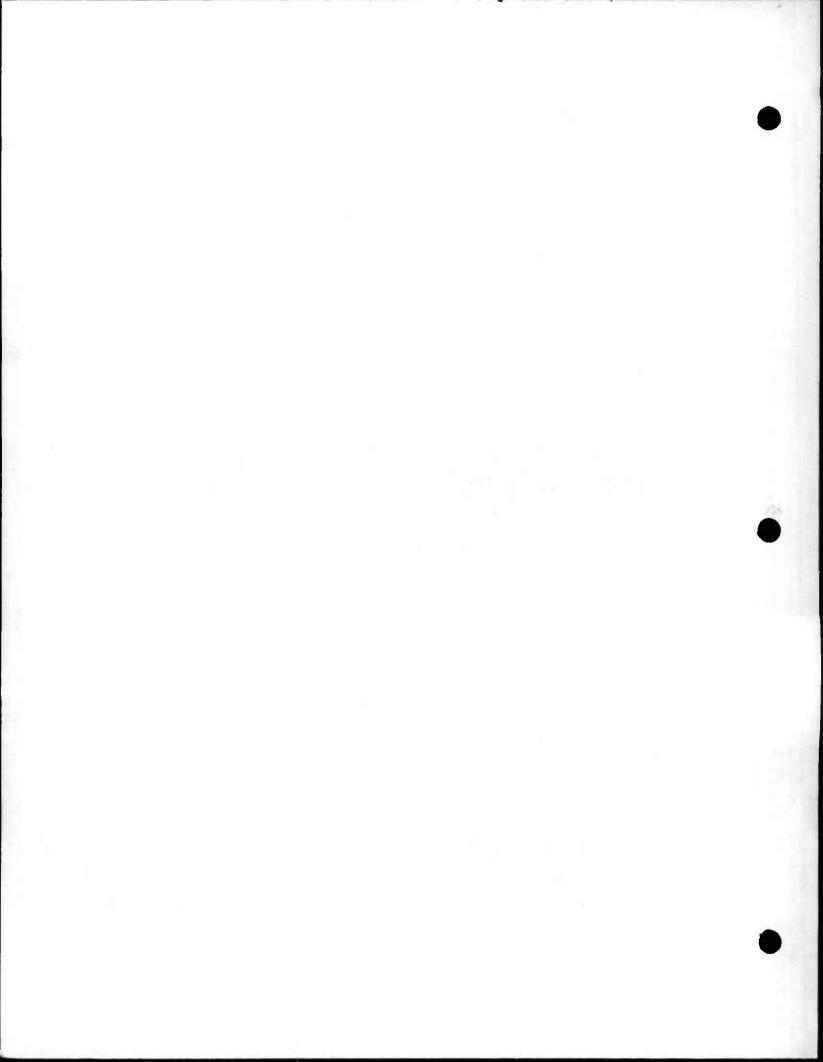
permit.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF OFATH DAY William Benjamin Carraway, Jr. April 21, 1995 10:50 4. SOCIAL SECURITY NUMBER 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 6. BIRTHPLACE (State or Foreign DAYS HOURS 1 XM 2 - F 212-16-0700 78 Oct. 21, 1916 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Anne Arundel Medical Center Annapolis Anne Arundel RESIDENCE OF DECEDENT Maryland Anne Arundel 10c. CITY, TOWN OR LOCATION Annapolis 10e. STREET AND NUMBER 101. ZIP CODE 226 Garden Gate Lane 21403 United States 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specity Yes or No—
It yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married 3 Widowed 4 Divorced Catteasian 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ost of working Elementery/Secondary (0-12) College (1-4 or 5+) 12 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) William B. Carraway, Sr. Lizzie Murphrey 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) William B. Carraway Taney Ave., Annapolis, Md., 21401

North Carolina DIRECTOR 10d. INSIDE CITY 1 YES 2 NO FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 14. RACE — American Indian, Black, White, etc. BY COMPLETED Federal Government Utilities Foreman Naval Experimental Sta. BE 2 20a. METHOD OF DISPOSITION
1.XI Surial 2 Cremation 3 20b. PLACE AND DATE OF DISPOSITION (Nama of OATE 20c. LOCATION - City or Town, State emetery crematory or other place)
Hillcrest Cemetery □ Donation 6 □ Other (Specify) 4-24-95 Annapolis, Maryland 21. SIGNATURE OF FUNERAL SERVICE 22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md.2140 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cade on each line. Approximata Interval Batween IMMEDIATE CAUSE (Final Onset and Death disease or condition___ resulting in death) Sequantially list conditions, AS A CONSEQUENCE OF If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events PART II. Other significant conditions contributing to death but not resulting in the underlying cerse given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS UN AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? PERFORMED? buch 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Rasidence 6 Other (Specify) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28a. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO 2 Accident Investigation 28a. PLACE OF INJURY — At home, farm, street, tactory, office building, etc. (Specify) 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Yown, State) 8 Could not be 4 Homicide 29a. CERTIFIER (Chock only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and manner as stated. reatigation, in my opinion, death occured at the time, data and place, and due to the ceuse(a) and manner as stated, SOMATURE AND TITLE OF CERTIF 29d. DATE SIGNEO (Month, 29c. LICENSE NUMBER D-21438 21 WIO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 0070 (Ph.#410-224-Michael J. LaPenta, M.D. 600 Ridgley Ave. #120 Annapolis, Md. 21401 31. DATE FILEO (MOOID, DOY, 2005) 1995 32. REGISTRAR'S SIGNATURE

Talia Davidson Revolath



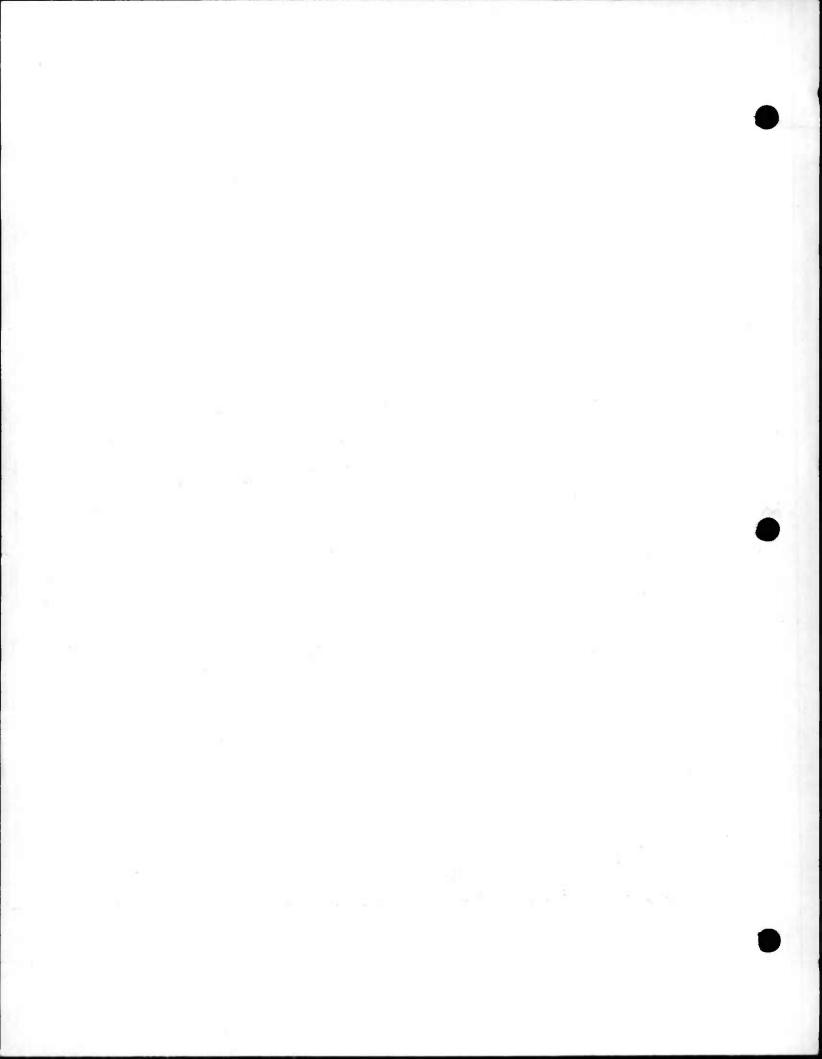
	1 - STATE REGISTRAR	STATE OF MARYL	CERTIF	ICATE O		MENTAL HYGIEN REG. NO	1 2	6-95 11:50AM
	1. DECEDENT'S NAME (First, Middle, Last)  EVELYM, M.	Chamb	Evelyi CVS	n M. Chamb	ers	2. DATE OF OEATH		YEAR 1150 AM
	211 2- 1101	5. SEX 6. AGE	(In yrs. lest birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	18	BIRTHPLACE (State or Foreign Country 5
стов	90. FACILITY NAME (If not institution, give street Arundel RESIDENCE OF DECEMENT	L Medical			OR LOCATION OF E			ne Arundel
DIREC	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOC	ATION	3,		10d. INSIDE CITY LIMITS?
	MD Anne 100. STREET AND NUMBER	e Arundel		Annapo	OTIS 101, ZIP CODE		10a, CITIZE	1 √ YES 2 □ NO
FUNERAL	504 L'udlow Road				214	01	1	ted States
BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 KNOX	If yes,	ECENDENT OF HISPA specify Cuben, Mexic ES 2 NO Speci	NNC ORIGIN? (Specify Yean, Puerto Rican, etc.)		e. RACE — American Indian, Black, White, etc. Specify: White
ETED.	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)		16e. DECEDENT'S (Give kind of tille. Do NOT us	work done during r	FION most of working	16b. KIND OF BU	ISINESS/INDUS	
COMPLI	12		Но	memake	er		Но	me
	17. FATHER'S NAME (First, Middle, Last)  Charles E. My	ore			18. MOTHER'S N	AME (First, Middle, Meider		
) BE	19e. INFORMANT'S NAME (Type/Print)	ers	19b. MAILING	ADDRESS (Street	t and Number or Rural	Ruth Russ  Route Number, City or Tov		ode)
5	Russell Chambe	ers				apolis, Mar		
	20a. METHOD OF DISPOSITION 1 Suriel 2 Cremation 3 Remov	rel from State cert	PLACE AND DATE	OF DISPOSITION (	Name of	DATE 20c. LC		y or Town, State
8 14	2) SIGNATURE OF FUNERAL SERVICE LICE	MSEE )	Hillcrest	Cemete 22, NAME	AND ADDRESS OF F	9/95 Ani	napolis	Maryland
	Davald L.	Litor		147	Duke of (	Gloucester	St. An	Funeral Home
	23. PART I. Enter the diseases, or co shock, or heart fellure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death)	CAM	CONSCOUENCE OF	m	UEST.	on as cardiac or reap	iratory arres	Interval Between Onset and Dasth
RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	A	CONSEQUENCE OF	YON	MI			Le HOURS
CERT	resulting in death) LAST							
MEDICAL	PART II. Other significant conditions	contributing to death b	ut not reaulting	n tha undarlyi	ng cause given in	Part i. 24a. WAS AN PERFOI	RMED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	F DEATH YE	S 🗆 NO J	UNCERTAL	N 🗆		1 TES 2 NO
YSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL:	26. PLACE OF DEAT	OTHER:		6 Other (Specify)		
ву РНУ	27. MANNER OF DEATH  1 Neturel 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM	URY	JURY AT YORK? YES 2 NO	28d. DESCRIBE HOW	NJURY OCCUI	RED
8	3 Suicide a Could not be 4 Homicide delermined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, s	street, factory, off	Ice	281. LOCATION (Street City or Town, State)	end Number or	Rural Routa Number,
COMPLET		AN: To the best of my knowl On the basis of examination						euse(e) and manner ee stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER	- MD			29c. LICENSE NUI D383		29d. DATE S	IGNEO (Month, Pay, Year)
01	30. NAME AND ADDRESS OF PERSON WHO	ATSCHO		Print) 2	75 WES	75.	Ann	MD 21401
	31. DATE FILED (Month, Day, Year)  APR 27 1995	32. REGISTRAR'S SIGN	ATURE LOC Randall					

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	4. SOCIAL SECURITY NUM		5. SEX	8. AGE (In y	yrs. last birthday)	F UNDER t	TEAR	IF LINDER	24 HRS. 7.	DATE OF BIRTH		I. BIRTHPI	LACE (Stein or
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220	Be. FACILITY NAME (If not	institution, give	street and number)				TOWN OR		ON OF DEATH		9c. COUNT		
CTOR	2415 FOX	CREE	K LANE				Dav	ids	onvil	1e	ANN	EAR	JNDEL
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FUNERAL	1524 Fal	-	e Lane				106. 3	2	1114				states
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BE COMPL	17. FATHER'S NAME (FIG. Jian	oth and or ou		Cher				M:	in	Piret, Michille, Afeicler		Gu	
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	tXDBurtal 2 ☐ Cremat 4 ☐ Donation 5 ☐ Othe	fon 3 🗆 Res er (Specify)	moval from State		Ste					STATE OF THE STATE OF	Crown		
	21. SIGNATURE OF FUNES	AL SERVICE	ICENSE	1	7. 000	Action 1997		_	SS OF FACILITY		CIOWI	15 V I	ille,
	23. PART I. Enter the shock, or	diseases, or heart failure	r complications that a. List only one cau	it caused th	he death. Do i	Dul	ce c	of (	31ouc	r Funer ester s cardiac or resp	st 7	Anna	polis
7	23. PART I. Enter the shock, of IMMEDIATE CAUSE (F disease or condition resulting in death)	neart failure	a. Due to	(OR AS A CO	ONSEQUENCE O	Dul- not enter th	te de mode	of (	Glouc ng. such as	ester s	st 7	Anna	Approxi
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DIVISION OF VITAL RECORDS, P.O. BOX 68760.	OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the
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ID 21215-0020

Pages 1, 2, 3 should permit. page 5 should be detached for use as the burial-transit the hospital or attending physician. the funeral director, completely filled in by 5 cremation n and com to burial, the attending physician Mental Hygiene prior to and the pt. of Health a has be Dept. this certificate h

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 2. DATE OF DEATH MATRY cros han 0 22 A SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 213-18-9821 1 M 2 Feb. 9, 192 Maryland 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Anne Arundel Medical Center Annapolis Anne Arundel 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 TES 2 NO Maryland Anne Arundel Severna Park 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? U.S.A. Hollyberry Road 21146 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 25 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-II yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. RACE — American Indian, Black, While, etc. 1 Never Merried 2 Nerried BY 1 TES 2 NO Specify: Specify: 3 Widowed 4 Divorced Caucasian 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) COMPLET Elementery/Secondary (0-12) College (1-4 or 5+) 12 +Homemaker Home once 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) 7 Lawrence L. Krepner Helena M. Hook BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code). 2 322 Hollyberry Road Severna Park, MD 21146 Charles J. Croghan pe 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 200. METHOU OF DISPOSITION

1 Buriel ZY Cremetion 3 Re
4 Donation Other (Specify) must Metro Crematory 4 - 28 + 1995Baltimore, MD examiner TATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Barranco & Sons Funeral Home 21146 495 Ritchie Hwy Severna Park, 22. PART I. Enter the disesses, or compock, or heart fellure. U medical lications that coused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory screet, Approximate only one cause on each line. interval Between IMMEDIATE CAUSE (Finel Onset and Death the disame or condition Metastatic Ovarian event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): If sny, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated evente resulting in desth) LAST 9 Injury, PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? shows any 1 TES 2 NO 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES  $\square$  NO  $\square$  UNCERTAIN  $\square$ 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) item HOSPITAL: OTHER: 1 - YES 2 -40 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 26e. DATE OF INJURY 28c. INJURY AT 26d, DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending M 1 YES 2 NO After t BY 2 Accident 26t. LOCATION (Street end Number or Rural Route Number, City or Town, Stete) 26s. PLACE OF INJURY — At home, lerm, street, tectory, office building, etc. (Specify) 3 Sulcide DIRECTOR: A hours after of 00 COMPLETED 6 Could not be 4 Homicide 28 item 1 SERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) end menner es stated. TO THE HOSPITAL TO THE FUNERAL I be filed within 72 h 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 041683 104. 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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32. BEGISTRAR'S SIGNATURE

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ANDREW SAMUEL 31. DATE FILED (Month, Day, Year)

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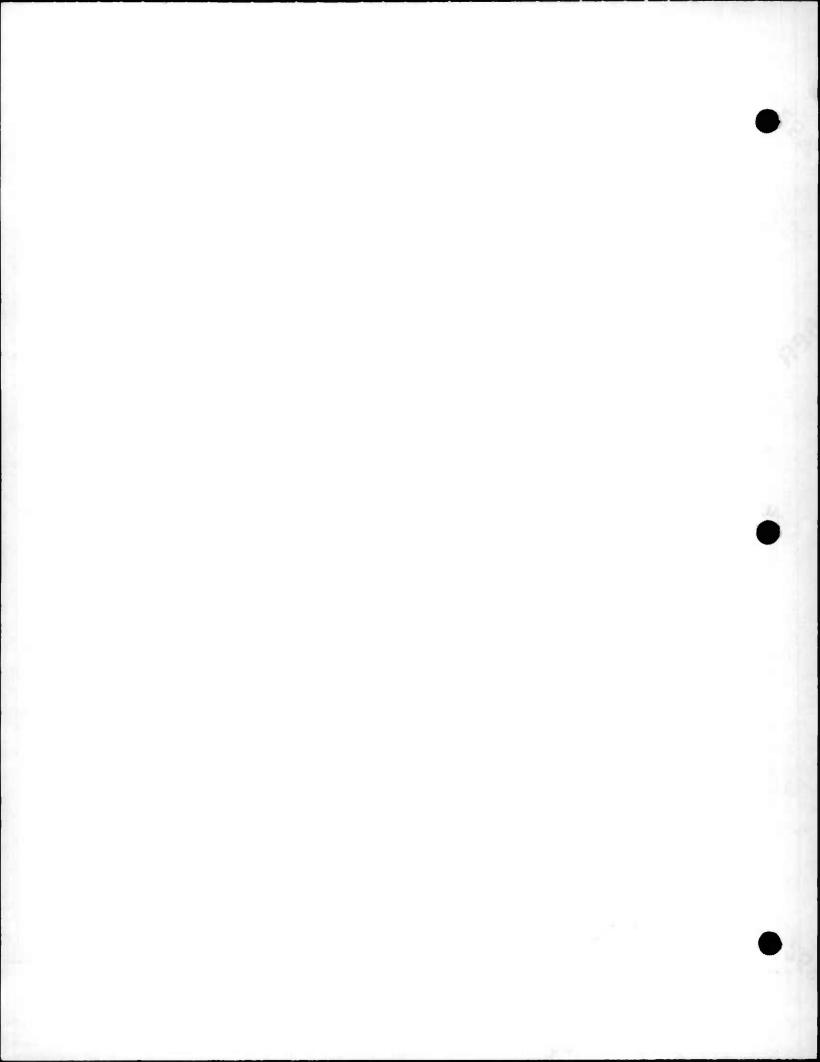
Paul A. DeVor 31. DATE FILEO (MONTH, DBY, YEAR) APR 10 1995

Devore,

M.D.,

	1 - STATE REGISTRAR			CERTIF	ICALE	OF DEATH		REG. NO	).		
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE	E OF DEATH	DAY	YEAR	3. TIME OF DEATH
	John S. C	annon, S	Sr.					ül 2.	1995	TEAH	4:55 P.
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yr	s. last birthday)	IF UNDER 1 Y		7. DATE	OF BIRTH		8. BIRTH	PLACE (State or Foreign
	718-14-9494 9a. FACILITY NAME (If not institution, give:	1 M 2 F	88	YRS.		WN OR LOCATION OF	Mar	th, Day, Year)			ington, D
TOR	Washington Advent		ital			na Park	DEATH		Mont		ry County
DIRECTOR	10a. STATE 10b. COUNT Maryland Anne	Arundel			Iland I						10d. INSIDE CITY LIMITS? 1 X YES 2 NO
۲	10e. STREET AND NUMBER			110.	LIGHT I	101. ZIP CODE			10e CITI	ZEN OF V	WHAT COUNTRY?
NER/	802 Walnut Avenue	2				20714			2.0		tates
BY FUNERAL	11. MARITAL STATUS  1 Never Married 2 Married  3 W Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2	₩ NO	If ye	DECENDENT OF HISP.  a, specify Cuban, Mexic  YES 2 NO Specific No.	can, Puarto	N? (Specify Ye Rican, stc.)	a or No-	14. RACI Black Speci	,
	15. DECEDENT'S EDU	ICATION	1 40				Total Control				White
1	(Specify only highest grade	completed)	-	(Give kind of life. Do NOT L	Work done during material	PATION og most of working	16	b. KIND OF BU	JSINESS/IND	USTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 +	+)	Host				Railro	ad		
Ö	17. FATHER'S NAME (First, Middle, Lest)					18. MOTHER'S N	AME (First,	Middle, Malder	n Surname)		
BEC	John L. Cannon					Maude	Lilly	У	ŕ		
8	19a. INFORMANT'S NAME (Type/Print)			19b. MAILIN	AOORESS (St	reet end Number or Rura			vn State Zin	Code)	
2	John S. Cannon, 3	Jr.	0.00			s Street,					DC 20018
	20e. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Rem	novat from State		CEAND DATE	OF DISPOSITIO	N (Name of	OAT	TE 20c. L	DCATION (	City or To	wn, State
	4 Donation 5 Other (Specify)	211	Fo:	ct Lin	coln C	emetery 4	1/5/9	5 Bre	ntwoo	d. N	faryland
	21. SIGNATURE OF FUNERAL SERVICE LI	OCHSES									
			/ /	8	22. NA	E ANO ADDRESS OF	ACILITY	. 1 77	-		aryrana
	- XI	1) 1/2	M		For t	E ANO ADORESS OF F	Fune	ral Ho	me, I	nc.	
-		250	all		22. NAM Fort	Lincoln  Bladensb	Funer Tuner urg F	ral Ho	me, In	nc.	
	23. PART I. Enter the diseases, or ahock, or heart failure.	complications the	t caused the	death. Do	22. NAM Fort	Lincoln  Bladensb	Funer Tuner urg F	ral Ho	me, In	nc.	MD 20722
	IMMEDIATE CAUSE (Finel	complications the	t caused the	death. Do	22. NAM Fort	Lincoln  Bladensb	Funer Tuner urg F	ral Ho	me, In	nc.	MD 2072
	IMMEDIATE CAUSE (Finel disease or condition	List only one cau	se on each	line.	Fort 340]	E ANO ADORESS OF E Lincoln Bladensb mode of dying, au	Funer Funer urg F	ral Ho	me, In	nc.	MD 20722 Approximete interval Betwee Onaet and De
	IMMEDIATE CAUSE (Finel	Arteri	ise on each	line.	22. NAM Fort 3401 not enter the	Lincoln  Bladensb	Funer Funer urg F	ral Ho	me, In	nc.	MD 20722
Z	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Arteri	ise on each	rotic	22. NAM Fort 3401 not enter the	E ANO ADORESS OF E Lincoln Bladensb mode of dying, au	Funer Funer urg F	ral Ho	me, In	nc.	MD 20722 Approximete interval Betwee Onaet and De
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WAS AN PERFO 1 VES SCRIBE HOW	Me, Internative and Autopsy RMED?  2 X No  INJURY OCC  and Number of the day of the total and due to the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of the lead of t	Ood, pat,  24b.  URED  Or Rural R  d. couse(a)	MD 2072  Approximate interval Betwo Onaet and De Years  Were autopsy pindin Available Priori to Completion of Causi of Death?  1 Yes 2 No

D., 4203 Queensbury Road, Hyattsville, Maryland 37. REGISTRAR'S SIGNATURE Shurlson Randell



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) (John Franklin Corkill, Sr.) 2. DATE OF DEATH 3. TIME OF DEATN JOHN APRTI. T n FRANKLIN CORKILL 6:50 P M 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 015-03-9294 1 X M 2 | F DAYS HOURS 87 Sept. 4, 1907 South Dakota Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR 8402 26th PLACE ADELPHI PRINCE GEORGES RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Adelphi 1 - YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10g, CITIZEN OF WHAT COUNTRY? 8402 26th Place funeral director, page 5 should be detached for use as the burial-transit 20783 U.S.A. 13. WAS DECENDENT DF NISPANIC ORIGIN? (Specify Yes or Nohours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FDRCES? 1 YES 2 KNO 14. RACE — American Indian Black. White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES 1 YES 2 X NO Specify: BY 3 Widowed 4 Divorced Specific White 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION early only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 4 Electrical Engineer F.C.C. once. 17. FATHER'S NAME (First, Middle, Lest) 18. MOTNER'S NAME (First, Middle, Maiden Surneme) at Bertram E. Corkill BE Hanna т. Thompson 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Loretta L. Corkill 8402 26th Place, Adelphi, Maryland Pe 20e. METHOD OF DISPOSITION

1 X Buriel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Fort Lincoln Cemetery 4 Donation 5 Other (Specify) 4/13/95 Brentwood, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. on the 4739 Baltimore Ave., Hyattsville, MD medicai 23. PART I. Enter the diseasea, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, and completely filled in by burial, cremation, or remo Approximata ahock, or heart failure. List only one ceuse on each line. **IMMEDIATE CAUSE (Final Onest and Death** other traumatic event, the disease or condition_ GUNSHOT NSHOT WOWD OF HEAD OUE TO (OR AS A CONSEQUENCE OF): resulting in death) executed with CERTIFICATION Sequentially list conditions, OUE TO (DR AS A CONSEDUENCE DE): 2 if any, leading to immediate cause. Enter UNDERLYING Hygiene prior CAUSE (Disease or Injury DUE TO (DR AS A CONSEDUENCE OF): that initiated events resulting in death) LAST signed by the atter Health and Mental PART il. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIDE TO any COMPLETION DF CAUSE OF DEATN? 1 YES 2 ND shows a YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has b. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) OR ATTENDING PHYSICIAN: The certificate the State OTHER:
4 □ Nursing Home XX Residence 6 □ Other (Specify) 1 XYES 2 NO 1 Inpatient 2 ER/Outpatient 3 I DOA 27. MANNER OF DEATH 410 95 FOUND 28b. TIME DF INJURY 400 POUND After this ce leath with the marked, 28c, INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Netural 1 YES 2 ND SUBTECT SHOT BY SELF After Investigation 2 Accident 28e. PLACE OF INJURY — At he hulldirin, etc. (Specify) 261. LOCATION (Street and Number or Rural Route 28 is DIRECTOR: A 8 Could not be COMPLETED HOME 4 Homicide determined ADELAPH! 8402 TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTS be filed within 72 hours at IMPORTANT: If Item 2 29e. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the c ion end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(s) end manner es stated. 29b. SEGNATURE AND TITLE OF 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE APRIL 2 M.E 1995 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIO 111 PENN STREET BALTIMORE, MARYLAND 21201 MX 31. DATE FILED (Month Day,

DIVISION OF VITAL RECORDS, P.O. BOX 68760

APR 13 1995

DHMH-18 Rev 1/89

Armite grand the stand

TO THE MISHTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within zer hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	-	REGISTRAR		CEF	RTIFIC	ATE C	F DEATH		REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)	ret		irti.	S		2. DATE OF MONTH	F DEATH	995	YEAR 3	TIME OF DEATH
		4. SOCIAL SECURITY NUMBER // 215-64-5508 90. FACILITY NAME (If not institution, give	1 🗆 M 2 💢 F	(In yrs. lest bii	YRS. MO	NTHS DAY	8 HOURS MIN.		Day, Your, Der 15,	1929	Mary 1	CE (State or Foreign and
9	5	Malcolm Grow Medic	cal Center		96		amp Springs				e Georg	
o Charles		Maryland Prince	e George's	1	Oc. CITY, TO	OWN OR LO		Mar1bor	ο ο			1. INSIDE CITY LIMITS?  YES 2 \( \backsquare \) NO
A CONTRACTOR		6014 Crane Highway					10f. ZIP CODE	20772		_	EN OF WHAT	COUNTRY?
2	5	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 _ YES IF YES, GIVE WAR OR D	2 // NO	0	It yes,	PECENDENT OF HISPA specify Cuben, Mexic (ES 2 NO Spec	an, Puerto Ak	(Specify Year can, etc.)	or No 1	Black, WI	American Indian, hite, atc.
Once.		15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (9-12) 7th grade	College (1-4 or 5+)	(Give I	kind of work NOT use re	tired.)	ATION most of working			Graphi		ems
at once		17. FATHER'S NAME (First, Middle, Lest)  JOSEPH E. S	avoy				18. MOTHER'S N	AME (First, Mi		Surname)	c Syst	dis
TO BE		190. INFORMANT'S NAME (Type/Print) Linda Washington (Dau	ighter)	196. M	A Crar	ne High	et and Number or Rural		r, City or Town	n, State, Zip C		
nust be		20e, METHOD OF DISPOSITION 1 \( \tilde{D} \) Burlel 2 \( \tilde{D} \) Cremetion 3 \( \tilde{D} \) Rem	206	PLACE AND	DATEOFD	SPOSITION	(Name of	DATE	29c. LO	CATION — CIT	ty or Town,	State
medical examiner must be notified at once.		4 Donation 8 Onner (Specify)  21. SIGNATURE OF FUNERAL SERVICE LI			7017 00	22 NAME	AND ADDRESS OF F	T Home,	Inc.	nton, M		<u>a</u>
or remova.		23. PART I. Enter the diseases, or	complications that cause	the deeth	. Do not	433	9 Hunt Place	e, N.E.	Washi	ngton,	D.C.	20019 Approximata
		ahock, or heart failure IMMEDIATE CAUSE (Finel disease or condition resulting in daath)	List only one cause on a	leis to	o a		Wascula					Interval Between Onset and Death
raylerie prior to build, cremation, or other traumatic event, the RTIFICATION		Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS A									
CER OF		reaulting in death) LAST	d									
amy in		PART II. Other algnificant condition	a contributing to death b	ut not resu	ilting in th	he underly	ring ceuse given in		PERFORI	MED?	COA OF	RE AUTOPSY FINDINGS ILABLE PRIOR TO IPLETION OF CAUSE DEATH?
23 shows		DID TOBACCO USE CONT						N 🗆			1	YES 2 NO
item state		25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO	HOSPITAL: 1   Inpatient 2   ER/Outp	atlent 3 121	01	THER:	ome 5 🗆 Residence	8 🗆 Other (	Specify)			
s marked, or		27. MANNER OF DEATH  1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28	b. TIME OF		INJURY AT WORK?  YES 2 NO	28d. DESC	RIBE HOW IN	JURY OCCU	RED	
28 is		3 Suicide 8 Could not be determined	28s. PLACE OF INJURY building, stc. (Spec	- At home,	term, atree	t, factory, o	ffica	28f. LOCAT City or	ION (Street as Town, State)	nd Number or	Aural Route	Number,
		29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC CHOCK (Check only one) 2 MEDICAL EXAMINE	ICIAN: To the best of my know	ledge, death on and/or inves	occurred at	the time, d	eta and place, and due	to the cause	e(a) and man	ner as stated.	cause(s) and	manner as stated.
IMPORTANT: If I		296. SIGNATURE AND TITLE OF CENTIFIES	dujue M	9			PAC. LICENSE NU	MBER		29d. DATE S	IGNED (Mor	oth, Day, Year)
1		30. MAME AND ADDRESS OF PERSON WHO	o completed cause of DE	ATH (ITEM 27	Type, Prin	Ray	bum CI.	Cas	n M	2000	744	
		APR 13 1995	37. REGISTRAR'S SIGN	TYPE		/		19		,	1-1-5	

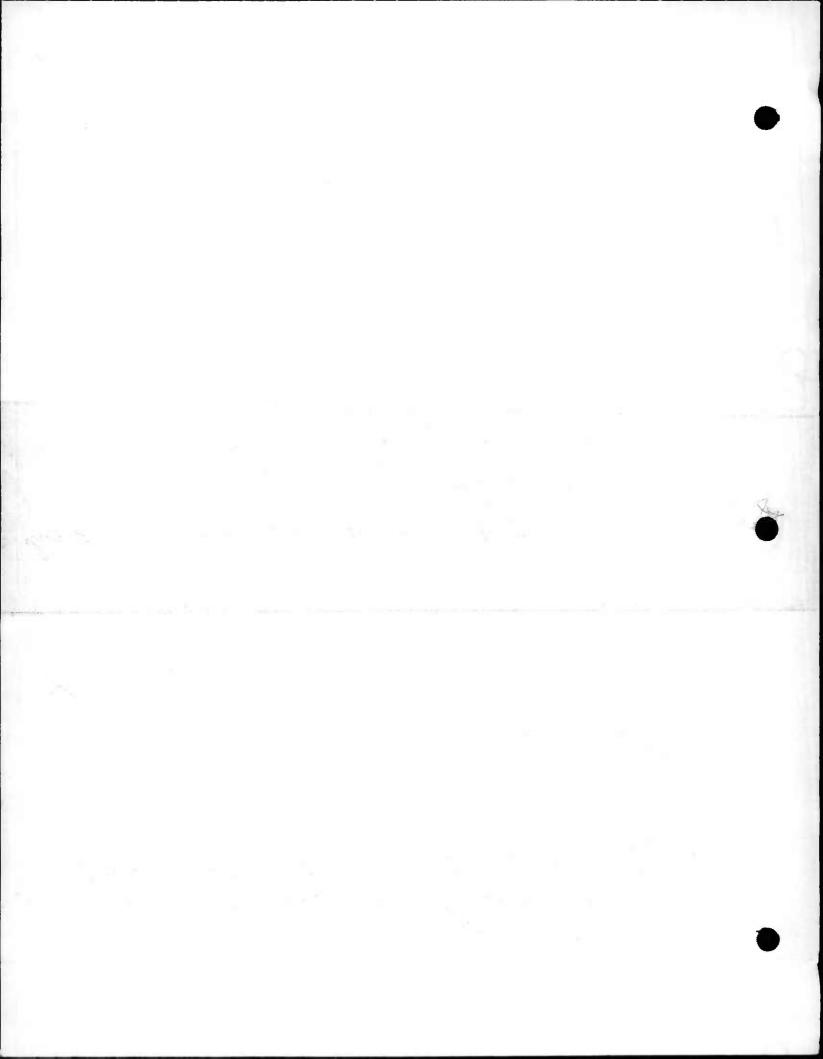
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DIVISION	

DIVISION OF VITAL RECORDS, P.O. BOX 68760  TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE POWERAL URECTOR. After this certificate has been signed by the artending physician and completely lifed in by the tribing the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the proof of the pr
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FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR			SERIIF	ICAL	E OF	DEATH		REG. NO.			
	1. OECEDENT'S NAME (First, Middle, Last)								DATE OF DEATH			3. TIME OF DEATH
	James	Henru	C	พพน				\ \A\.	pril 11.	1995	YEAR	11:30A M
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs.		E Inter-	R 1 YEAR	IF UNDER 24 HRS.		PATE OF BIRTH	177		
	577-10-4812	1 X M 2 F	9.3	YRS.	MONTHS	DAYS	HOURS MIN.	1 (	Month, Day, Year)		6. BIRTH	PLACE (State or Foreign y)
			7.3	THS.				_	JN 11. 19	901	VIRC	GINIA
ا ہ	9e. FACILITY NAME (If not institution, give str	reet and number)			9b. CITY	Y, TOWN C	OR LOCATION OF	DEATH		9c. COU	NTY OF D	EATH
Ö	DOCTORS HOSPITAL				L	ANHA	M			PRIN	CE G	GEORGES
DIRECTOR	RESIDENCE OF DECEDENT  10e. STATE 10b. COUNTY											
<u></u>						OR LOCAT						10d. INSIDE CITY LIMITS?
	NA NA			Was	shing	gton	, D.C.					1 X YES 2 NO
Z	10e. STREET AND NUMBER					101	ZIP CODE			10g. CITI	ZEN OF W	/HAT COUNTRY?
띪	806 20th St., N.E.						20002			Unit	ed 9	tates
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT			13.	WAS DEC	ENGENT OF HISP	ANIC O	RIGIN? (Specify Yea		14. RACE	- American Indian.
	1 Never Married 2 🔀 Married	FORCES? 1 [		NO		If yes, sp	ecify Cuban, Mexi	lcen, Pu	erto Rican, etc.)		Black	, White, atc.
B	3 Widowed 4 Divorced	IF TES, GIVE THE	N ON OALES			1 _ YES	2 M NO Spe	cify:		1	Speck	lack
	15. OECEDENT'S EDUC	ATION	16.0	DECEDENT'S	USUAL	CCUPATIO	ON		18b. KIND OF BUS	IMEGGUANO		
E	(Specify only highest grade of	completed)		(Give kind of a life. Do NOT us	work done	during mo	st of working		TOU. THIS OF BUS	UNIVEGRA	ODINT	
7	Elementary/Secondary (0-12)	College (1-4 or 5+)							CONTEMP	OMTO	A.T	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		GL	M COM	UNKE	IN/ PP	INTER		CONSTRU		N	
۲ ا									irst, Middle, Melden	Sumame)		
BE	THORNTON CURRY						EMMA					
၉	19e. INFORMANT'S NAME (Type/Print)								Number, City or Town			
-	JULIA M. CURRY		8	306 20	th S	T.,N	I.E. Wa	shi	ngton, D	.C.	2000	2
	20e. METHOD OF DISPOSITION 1 Duriel 2 Cremetion 3 A Remo	and the second	20b. PLAC	EANDDATE	OF DISPOS	SITION (Na		7.		CATION -		
	1 ☐ Buriel 2 ☐ Cremetion 3 ☑ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State	Z.TOM	RAPT	CHP	CEM	ETERY					VIRGINIA
	21. SIGNATURE OF PUNERAL SERVICE LICE	ENSSE	LOTON	DALL			D ADORESS OF			хых п	وبابت	ATKGTNIA
	· (10. 0	D. A.		MOEC					OPE FUNEI	RAT. H	OMES	
	· wey s	voke x	1 .	4859	5	5538	MARLBOI	RO F	PIKE, FOR	RESTV	ILLE	,MD 20747
	23. PART i. Enter the diseases, or co ahock, or heart failure. L	omplications but	ceused the	deeth. Do r	not anter	the mo	de of dying, su	ich aa	cerdiac or respin	ratory arr	eat,	Approximate
-	anock, or heart failure. L	ist only one chuse	e on aach ii	ne.								interval Between
	IMMEDIATE CAUSE (Final disease or condition	CILI	211	201	1	10	110-	0 4	11			Onset and Death
}	resulting in death)	20B	2000	< TTU	- 7	151	MITIC	119	7-6	- au	SC	3 days
_		DOE 10 (0	OR AS A CONS	SECUENCE OF	rj:							
8	Sequentially list conditions,	Due to	D 40 4 00	eoueros s								
ĖI	if any, leading to immediate	DOF 10 (0	m as a cons	EOUENCE OF	h):							1
< II												į l
<u>5</u>	CAUSE (Disease or injury	41-										
TIFICA	ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events	OUE TO (O	OR AS A CONS	SEOUENCE OF	F):					-		
ERTIFICA	CAUSE (Disease or injury	OUE TO (O		SEOUENCE OF	<b>ጉ</b> :							
	couse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST		OR AS A CONS			nderlule	o cours alua-	n Dow	l las mass	ALEBOGO		
	ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events		OR AS A CONS			nderiying	g cause given i	n Part	i. 24s. WAS AN / PERFORI		24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
	couse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST		OR AS A CONS			nderlying	g cause given i	n Part		MED?	24b.	
EDICAL	ceuse. Enter UNDERLYING CAUSE (Disease or injury that infilted events resulting in deeth) LAST  PART II. Other significant conditions	contributing to d	eath but no	t resulting l	n the ur			in Part	PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
MEDICAL	couse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST	contributing to d	eath but no	t resulting l	n the ur			_	PERFORI	MED?		AMILABLE PRIOR TO COMPLETION OF CAUSE
JAN: MEDICAL CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in deeth) LAST  PART II. Other significant conditions  DID TOBACCO USE CONTR  25. WAS CASE REFERRED TO MEDICAL	contributing to d	eath but no	t resulting l	n the ur	NO 🗆		_	PERFORI	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
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(Month, Day, Veer)



DIVISION OF VITAL RECORDS, P.O. BOX 68760	L. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicia	DIDECTION this continuous brown stream for the strengton and commission flast in the the december of the continuous flast and the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of the stream of th
D S BALTIN	rithin 24 hours after death. Pag	latahy filled in by the farment di
P.O. BOX 6876	th certificate be executed w	amon bar acioin and andione
AL RECORDS,	law requires that the deal	se hear cinead by the att
DIVISION OF VITA	. OR ATTENDING PHYSICIAN: The	DIDECTION After this cardificate b
	-3	-

r attending physician. use as the bunal-transit permit. Pages 1, 2, 3 should TO THE FUSPITAL OR ATTENDING PHYSICIAN: TO THE FUNERAL DIRECTIOR: After this certificate be filed within 72 hours after death with the State IMPORTANT: If Item 28 is marked, or Item

		STATE OF M							MENTAL HYGIEN		5 1	3401
	1. OECEOENT'S NAME (First, Middle, Last)	C	ARPE	STIF	R	OF	DEAT	тн	2. DATE OF DEATH MONTH D	AY 7	9.5	3. TIME OF DEATH
	E77 74 1560	SEX	8. AGE (In yrs. less	birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year) 6/13/26		8. BIRTH Countr	7
стоя	9a. FACILITY NAME (If not institution, give street Holy Cross Hos					ver.			ATH		Was unty of b ntgo	
DIREC	10a, STATE 10b, COUNTY					ngt		D.C				10d. INSIGE CITY LIMITS? 1 X YES 2 NO
FUNERAL	100. STREET AND NUMBER 4671 A Street,	S.E.					200			1	TIZEN OF V	VHAT COUNTRY?
B	11. MARITAL STATUS 1 Never Merried 2 X Married 3 Widowed 4 Divorced	2. WAS DECEDENT FORCES? 1 [ IF YES, GIVE WA	YES 2 X	MED O		WAS DECE If yes, spe I PES	city Cuber	n, Maxicar	IC ORIGIN? (Specify Yes n, Puarlo Rican, etc.)		14. RACE Black	- American Indian, t, White, etc. ty: ack
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12) 12th	TION mpleted) College (1-4 or 5+)	(Gi	CEDENT'S We kind of w Do NOT us	work done e retired.)	CCUPATION during mos	of working	g	16b. KIND OF BU	SINESS/IN	-	
ш	17. FATHER'S NAME (First, Middle, Last) Lucius Epps		1 330						ME (First, Middle, Meiden ia Smith			
10 B	19a. INFORMANT'S NAME (Type/Print) Roland F. Carpe:	nter,					d Number	or Rural A	oute Number, City or Tow	n, State, Z		D.C. 2001
	1X Buriel 2 Cremetion 3 Remova 4 Donation 6 Other (Specify)  21. SIGNATURE OF FUNERAL PRIVICE LICENT  William O. Al	SERBLE	20b. PLACE A cemetery, crer	DL1V	et 22.	Ceme	ADDRES Br	oth	Wa Warry ers Fune a Avenue	shi ral	ngto Home	n D C
SERTIFICATION	23. PART i. Enter the diseases, or compands, or heart fellure. List immediate CAUSE (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	Hem  RUPT  DUE TO (6)	or sach line.	UENCE OF	SP ABA	the mod	o of dyli	ng, such	as cardled or reepi	iratory a	rrest,	Approximate interval Between Onset and Deat G HRS
MEDICAL C	PART II. Other aignificant conditions of	contributing to d	leeth but not re	sulting i	n the un	derlying	ceuse g	iven in f	Part i. 24s. WAS AN PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  1 YES 2 NO
SICIAN: P	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITALA	JSE OF DEAT			only one)	UNC	ERTAIN				
BY PHYS	27. MANNER OF OEATH  1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF II		26b. TIMI	4 🗆 Nun	26c. INJU WOR	RY AT		3 Other (Specify) 26d. DESCRIBE HOW II	NJURY O	CCURED	
ETED	3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF building, at	INJURY — At honic. (Specify)	na, farm, s	treat, tect	ory, office			28t. LOCATION (Street a City or Town, State)	and Numbe	er or Rural R	oute Number,
COMPL	29e. CERTIFIER 1 CERTIFYINO PHYSICIAI (Check only one) 2 MEDICAL EXAMINER: C											and menner as stated.
BE	296. SIGNATURE AND TITLE OF SENTIFIER	th	MO		-		29c. LICE	NSE NUM	BER	29d. DA	TE SIGNED	(Month, Day, Year)

11120 New Hampshi

30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

GARRY (UBCN, MD) 11120 NO

32. REGISTRAR'S SIGNATURE

31. DATE FILED (Month, Day, Year)

APR 10 1995

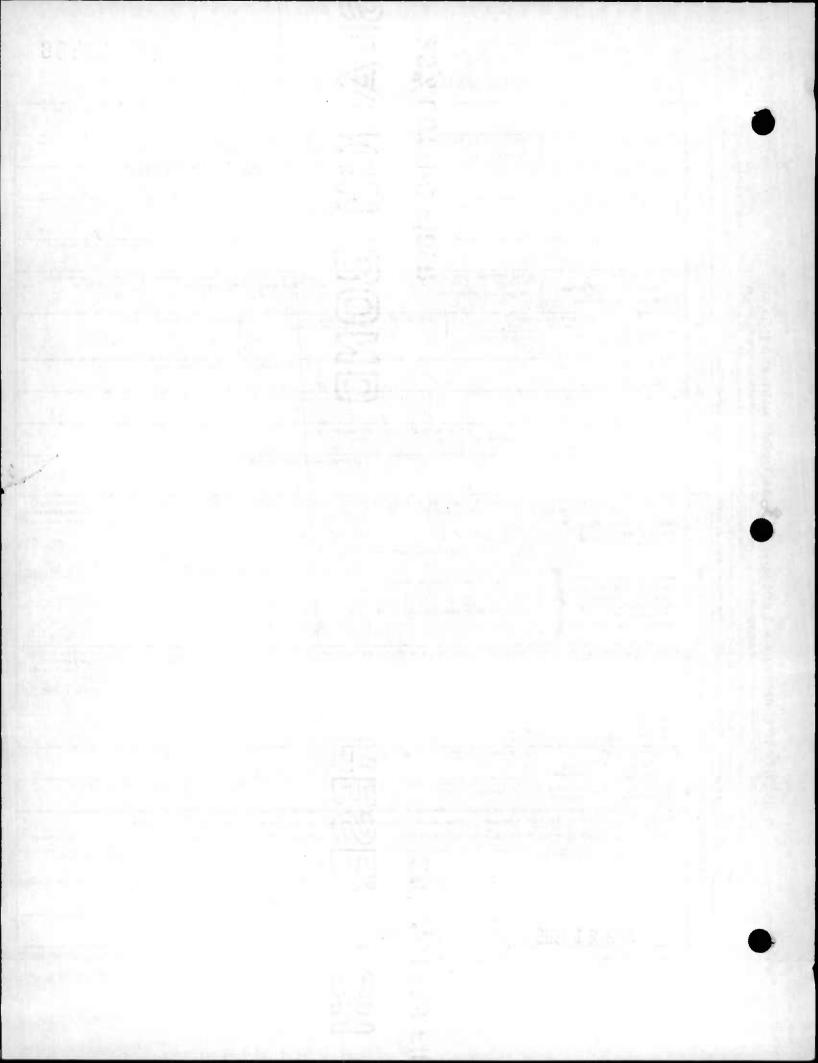
permit. Pages 1, 2, 3 should

- 4	REGISTRAR  1. DECEDENT'S NAME (First, I	Affection ( part)				IOAI	E OF	DLA		1	REG. N	0.				Δ.
	BYRON		Y CRUM							MONT 4		19	YEAR		E OF DEATH	A
i	4. SOCIAL SECURITY NUMBE		5. SEX	6. AGE (In yrs. Is	est birthday)	IF UNDE	R L YEAR	IF UNDER	24 HRS.	-	OF BIRTH	19	1995		State or Ford	ian
	218-12-6336		1 🖔 M 2 🗆 F	81	YRS.	MONTHS	DAYS	HOURS	MIN.	(Mont	27,	1014	914 Maryland			
	9a. FACILITY NAME (If not inst		street and number)	01		9b, CIT	Y, TOWN O	R LOCATE	ON OF D		41,		UNTY OF		ana	-
	Citizen		sing Home	<b>:</b>			Fred	eric	k			I	rede	erick	ζ	
ı		10b. COUNT	Υ		10c. CIT	Y, TOWN	OR LOCAT	ION							SIDE CITY	
	Maryland	Fre	derick		F	rede	rick								MITS?	0
	10e. STREET AND NUMBER			3.1			101	. ZIP CODI	E			10g. Cf	TIZEN OF	WHAT CO	OUNTRY?	
	8117 Broadv	iew D	rive					2	1701			Uni	ted	Stat	es	
	11. MARITAL STATUS 1 Never Married 2 h 3 Widowed 4 Divorce		12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2	NO	13.	If yes, spe	ENDENT Cooling	n, Mexic	en, Puerto	N? (Specify ) Rican, atc.)		14. RA	CE — Ame ck, White, city:	rican Indian	
	15. DECE	DENT'S EDU	CATION	16a. C	ECEDENT'S	USUAL (	OCCUPATIO	ON		168	. KIND OF B	USINESS/IN	DUSTRY	WII	irce	-
	Elementary/Secondary (0-	highest grade	College (1-4 or 5 -	the second	Give kind of le. Do NOT u	work done se retired.;	during mo:	st of workin	ng							
	7				Fari	ner					Dair	y far	m			
	17. FATHER'S NAME (First, Mid	ddle, Last)						16. MOTI	HER'S N	AME (First,	Middle, Maide	en Sumame)				
	William S	. Cru	um				14.4	Ma	amie	Μ.	Gro	shon				
	19a. INFORMANT'S NAME (Typ			1	9b. MAILING	ADDRES	S (Street a	nd Number	or Rural	Route Num	ber, City or To	own, State, 2	Sip Code)			
	Lois D. Sur	mmers		8	3849 T	Vate	rstre	eet E	Road	Wa.	lkers	ville	, MD	21	793	
8	20a. METHOD OF DISPOSITION 1-12 Buriel 2 Cremation	DN n 3 🗆 Rem	oval from State	20b. PLACI	ANDDATE	OF DISPO	SITION (Na	me of		DAT	E 20c. I	LOCATION -	- City or	Town, Stat	la.	7 1
	4 Donation 5 Other (	(Specify)		Resth	aven	Mem	orial	1 0	-1	011.1	21/05	E-ma	1 2	010	Mary1	an
	21. SIGNATURE OF FUNERAL						OLLA	L Gai	uen	5 4/	41190	rre	deri	CRe		
	~!//	. SERVICE LI	CENSEE"			22	. NAME AN	D ADDRE	SS OF F	CILITY						
	Hanny	SERVICETAL	Swere	-		22	. NAME AN	ID ADDRE	SS OF F	S	tauff	er Fu	nera	1 Ho	mes,	P,
	23. PART /. Enter the die	seases, or	complications (the	C t ceused the d	leath, Do	1	. NAME AN	Oposs	ss of f	S: own	tauff Pike	er Fu Fred	nera eric	1 Ho k, M	mes,	r,
	/	seases, or cent fallure.	Sovere	C t ceused the d	leath, Do	1	. NAME AN	Oposs	ss of f	S: own	tauff Pike	er Fu Fred	nera eric	1 Hok, M	mes, D 21	7.70
	immediate cause (Final disease or condition	seases, or cent fallure.	complications (the	t ceused the d	leath, Do	1 not anta	621 (	Oposside of dy	ss of FI	S: own	tauff Pike	er Fu Fred	nera eric	1 Hok, M	mes, D 21	7.70
	immediate cause (Fine	seases, or cent fallure.	complications (the	t ceused the d	leath, Do	1 not anta	621 (	Oposside of dy	ss of FI	S: own	tauff Pike	er Fu Fred	nera eric	1 Hok, M	mes, D 21	7 . 7 C
	immediate cause (Final disease or condition	seases, or cent fallure.	complications the List only one cau	t ceused the dise on each lin	leath, Do na.	not anta	621 ( If the mod	Oposs de of dy	SUMT	OWN	tauffe Pike diac or ree	er Fu Fred ppiratory	nera eric	1 Hok, M	mes, D 21	7.70
	immediate Cause (Fine disease or condition resulting in death)  Sequentially list condition	seases, or coart failure, el	complications the List only one cau	t ceused the dise on each ilr	EOUENCE O	not anta	621 ( If the mod	Oposs de of dy	SUMT	OWN	tauffe Pike diac or ree	er Fu Fred ppiratory	nera eric	1 Hok, M	mes, D 21	7.70
	shock, of he immediate condition resulting in death)  Sequentially list condition if any, leading to immediates. Enter UNDERLYIN	seases, or coart failure, al	complications the List only one cau	t ceused the dise on each ilr	EOUENCE O	not anta	621 ( If the mod	Oposs de of dy	SUMT	OWN	tauffe Pike diac or ree	er Fu Fred ppiratory	nera eric	1 Hok, M	mes, D 21	70
	Sequentially list condition resulting in death)  Sequentially list condition from the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of the sequential of th	seases, or of sert failure.	a. 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SON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

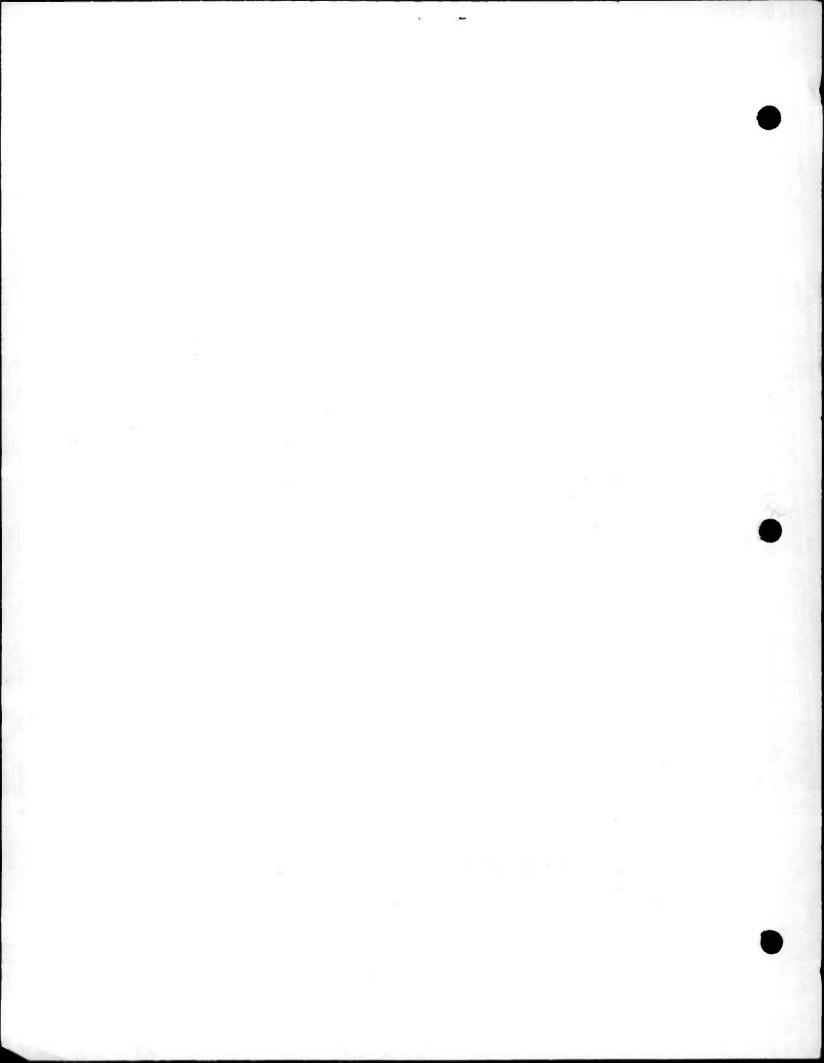
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		FOR 1 - STATE REGISTRAR		STATE OF	MARYLAI	ND / DEPA	RTMENT (	OF H	IEALTH AN	D MEI	NTAL HYGIEN	E		
		1. DECEDENT'S NAME (First	Middle, Last)			CERTIF	ICALE	OF	DEATH	12	REG. NO			3. TIME OF DEATN
		John	Lesli	e Carter							oril 2	19	995	12:30 P
		4. SOCIAL SECURITY NUME 195-03-277		5. SEX 1	6. AGE (In )	yrs. lest birthday) YRS.		YEAR DAYS	IF UNDER 24 HR HOURS MIN	8. 7. 1	DATE OF BIRTH (Month, Day, Year) OCC 4, 19	09	Country	
3 should		9e. FACILITY NAME (If not in			05		9b. CITY, TO	OWN (	OR LOCATION OF		ec 4, 13		TY OF DE	nsylvania
N	TOR	Montgomery		al Hospi	tal			lne					ntgan	
ages 1.	DIRECTOR	10a. STATE	10b. COUNT			10c. CI	TY, TOWN OR							10d. INSIDE CITY LIMITS?
mit.		Maryland 100. STREET AND NUMBER	Но	ward			Highla	-	. ZIP CODE			L 40 - 01711		1 YES 2X NO
ansit p	IERAL	13010 Wain	wright	Road				"	20777			0.0		States
the bunal-transit permit. Pages 1,	BY FUN	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divo		12. WAS DECEDEN FORCES? IF YES, GIVE	MAR OR DATE	ES	If y	es, sp	ENDENT OF HIS ecify Cuban, Ma 2 X NO Sp	ricen, Pu	RIGIN? (Specify Yearsto Ricen, etc.)	or No-	14. RACE Black, Specify	
S	9		EDENT'S EDU	CATION	WWI	6a. DECEDENT'S	DOO IAURUS	IDATI	ON .		444 1/11/2 05 21/4			White
for use			y highest grade	completed) College (1-4 or 5		(Give kind of life. Do NOT	work done duri	ing mo	est of working		16b. KIND OF BU	SINESS/IND	USTRY	
oetachec	COMPL	17. FATNER'S NAME (First, M	Vedella Carri	2		Owner					Antiqu		op	
8 6	ш		Carter						18. MOTHER'S		First, Middle, Meiden	Surname)		
5 should notified	TO B	19a. INFORMANT'S NAME (7				196. MAILIN	O ADDRESS (S	treet a			Number, City or Tow	n, State, Zip	Code)	
be no	-	John E. Cai								Road	Columbi	a, Ma	ryla	and 21044
must		20a. METHOD OF DISPOSITI 1 Burial 23 Crematio 4 Donation 5 Other	ION on 3 ☐ Rem (Specify)	oval from State	20b. PI cernete	LACE AND DATE	of DISPOSITIO	ON (Na	remator	~		CATION — C	A STATE OF	
ner an dire		21. SIGNATURE OF FUNERA		ENSEE	Da	LL Wasi	22. NA	ME AN	ND ADDRESS OF	FACILIT	Υ	rel,		Tanu
r removal.  redical examiner must be		Stan	ley	M. Lou	mer	-	Har   411	ry	H Witz Old Col	ke umb	Funeral	Home Ellic	Inc	City 21043
Hygiene prior to burlal, cremation, o or other traumatic event, the m	ERTIFICATION	23. PART I. Enter tha di shock, or hi IMMEDIATE CAUSE (Fin disease or condition reaulting in death)  Sequentially list condition if any, leading to imme- cause. Enter UNDERLY! CAUSE (Disease or inju- that initiated events resulting in death) LAS	ions, diate	DUE TO	LVVVV OR AS A CO OR AS A CO OR AS A CO	h iina.	mas Hea Hea Heros	vt	Dis			alory and		Approximate interval Between Onset and Dasti Minutes  Years  Years
	0	PART II. Other algnifica	nt condition	s contributing to	death but	not reauiting	in the under	riying	g cause given	in Part			24b. 1	WERE AUTOPSY FINDINGS
Dept. of Health and I	N: MEDICAL	DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF	DEATH Y	ES 🗆 NO	D [	] UNCERTA	AIN E	PERFOR	-		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
th the State De	SICIAN	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:		PLACE OF DEA	OTHER:	one)						
9 g	HYS	1 YES 2 PNO		1 Pinpetient 2 28e. DATE OF			4 - Nursing		e 5 🗆 Residen	7				
5 9	BY PI	1 Natural 5	Pending Investigation	(Month, D		28b. TIN	JURY	WO	URY AT RK? (ES 2 NO	266	. DESCRIBE NOW II	NJURY OCC	URED	
after d	9		Could not be fetermined	26s. PLACE O building,	F INJURY — atc. (Specify)	At home, farm,	street, lectory,	office		28f.	LOCATION (Street e City or Town, State)	nd Number o	or Rural Ro	ute Number,
2 =	COMPL	One) 2 MEDI	CAL EXAMINE											and manner sa atated.
be filed within 7	BE	296. SIGNATURE AND TITLE	OF CHITTINES	the 1	cos				29c LICENSE	UMBER	2	29d. DATE	SIGNED (	Month, Day, Year) 723, 1995
2 €	٩	30. NAME AND ADDRESS OF	PERSON WN	O COLLETED CAU	SE OF DEATH	(ITEM 27) (Type	a, Print)		D37	, 1		- 4		
		18til IVI	vice		-		- 00	JU	モファル	1 D	. 208:	32		
81		31. DATE FILED (Month, Day,		Julia di	Lucker	Rardall								



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the found after death, Page 6 may be retained by the hospital or attending physician.

TO THE EUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

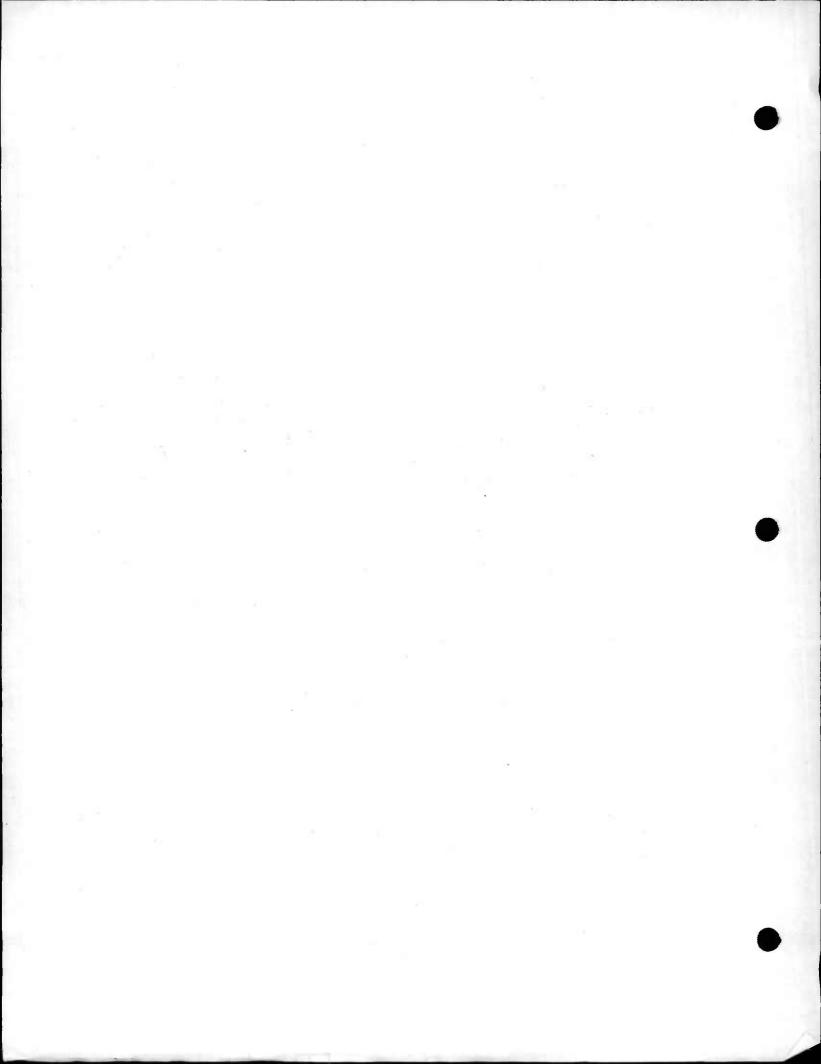
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR CER	TIFICATE (	OF DEATH	REG. NO	).	
	1. DECEDENT'S NAME (First, Middle, Last)	Ex-		2. DATE OF DEATH		3. TIME OF DEATH
1 1	Margaret Scott Cozad			Apr.	7 100	F 44 FF W
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. lest birt)	hday) IF UNDER 1 YE	AR IF UNDER 24 HRS.	?. DATE OF BIRTH		5 11:55 a M
		,,	YS HOURS MIN.	(Month, Day, Year)	Co	ountry)
1 1	A OZ			Mar.21,1		PA
_	9e. FACILITY NAME (If not institution, give street and number)	9b. CITY, TO	WN OR LOCATION OF D	EATH	9c. COUNTY C	OF DEATH
DIRECTOR	Meridian Nursing Center	Randa	llstown		Balti	more Co.
5	RESIDENCE OF DECEDENT				124101	more co.
#		C. CITY, TOWN OR L	DCATION			10d. INSIDE CITY LIMITS?
	Maryland Anne Arundel	Arnold				1 X YES 2 NO
4	10e. STREET AND NUMBER		10f. ZIP CODE		10g. CITIZEN C	OF WHAT COUNTRY?
8	517 Mystic Lane		21012		11	SA
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED	13. WAS		NIC ORIGIN? (Specify Ye		
	1 Never Merried 2 Married FORCES? 1 YES 2 NO	If ye	s, specify Cuban, Mexica	n, Puerto Rican, etc.)	■ 6	RACE — American Indien, Black, Whita, atc.
B	3 ★ Widowed 4 Divorced IF YES, GIVE WAR OR DATES	''	YES 2X XNO Specif	y:	S	Specify.White
۱۵	15. DECEDENT'S EDUCATION 16a. DECEDI	ENT'S USUAL OCCU	PATION	155 KIND OF BU	ISINESS/INDUSTR	
	(Specify only highest grade completed) (Give ki	ind of work done durin NOT use retired.)	g most of working	100. KIND OF BU	SINESS/INDUSTR	.*
ايرا	College (1-4 or 5 +)	1000		D. 1. 2		
Σ		rarian			ic Lib	rary
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			ME (First, Middle, Maider		
BE	Charles Gordon Watherwax		Ora	Elsie (S	cott)	
	19a. INFORMANT'S NAME (Type/Print) 19b. MA	AILING ADDRESS (St	eet and Number or Rural	Route Number, City or Tov	vn, Stete, Zip Code	)
입	Morton Cozad 517	Mystic	Lane, A	rnold, M	D 21	012
	20s. METHOD OF DISPOSITION 20b PLACE AND I	DATE OF DISPOSITIO		DATE 20c. LC		
	1 X Burial 2 Cremation 3 Removal from State   cemetary cremator	ry or other place)	·	1	-	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	<u>est Bur</u>	<u>ial Park</u>	4/12/95	Cyumb.	erland, MD
	21. SIGNATURE OF PUMERAL SERVICE LICENSEE	22. NAN	E AND ADDRESS OF FA	CILITY Kight	Funer	al Home
	NUVIAN J DUK	309	-311 Dec	atur St.	. Cumb	erland, MD
	23. PART i. Enter the diseases, or complications that caused the deeth.					
	ahock, or heert failure. List only one gluse on each line.	Do not enter the	mode of dying, aud	n es ceralec or reep	oratory arrest,	Approximate interval Between
1 1	IMMEDIATE CALIFE (Final	/				Onset and Death
	disease or condition resulting in death)	vom b	000			>/400
	DUE TO (OR AS A CONSEQUEN					- July
-	- ASCUD					lancada 1
Ĭ O	Sequentially list conditions,  DUE TO (OR AS A CONSEQUEN	ICE OF):				2 my Spaning
A	if any, leading to immediate cause. Enter UNDERLYING					
CERTIFICATION	CAUSE (Disease or injury	ICE OED				
Ē	thet initiated events resulting in deeth) LAST	· · · · · · · · · · · · · · · · · · ·				i
点	d		-			
	PART it. Other algorificant conditions contributing to deeth but not read	ting in the under	lving cause given in	Part I. 24s. WAS AN	AUTOREY	24b. WERE AUTOPSY FINDINGS
EDICAL	20011101101101101	iting in the under	iying couse given at	PERFO		AVAILABLE PRIOR TO
ă				1 _ YES :	2 (1)	COMPLETION OF CAUSE OF DEATH?
ME.		ncerta	15			1 YES 2 NO
	DID TOBACCO USE CONTRIBUTE TO CAUSE	OF DEATH	YES T NO		1	
₹	25. WAS CASE REFERRED TO MEDICAL		8. PLACE OF DEATH (Ch			
2	EXAMINER? HOSPITAL:	OTHER.		, , ,		
PHYSICIAN:	1 PES 100 1 Inpatient 2 ER/Outpatient 3 D		Home 5 Rasidence			
표	(Month Bey Man)	b. TIME OF 280	. INJURY AT WORK?	28d. DEŞCRIBE HOW	INJURY OCCURE	)
À	1   Matural 5   Pending	M 1	YES 2 NO	Sec		
	28a. PLACE OF INJURY — At home, building, atc. (Specify)	farm, street, factory,	offica	281. LOCATION (Street		val Route Number,
TED	4 Homicide determined			City or Town, State	,	
Ш	29a. CERTIFIER	and the latest terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal terminal termin				And the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s
P	(Check only   CERTIFYING PHYSICIAN: 10 the best of my knowledge, death of					
COMPLET	2 MEDICAL EXAMINER: On the beals of examination and/or invest	itigation, in my opini	on, death occured at the	time, data and place, as	nd dua to the cau	se(a) and manner as atated.
ш	28h SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUI	MBER	29d. DATE SIGI	NED (Month, Day, Year)
00	1001218551		D1507	)	DA.	.1
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)	(Fine Brief)	D15872		- my	114 1995
	Harold B. Bob, MD 7220 Park	Hts. A	re., Balt	imore, M	1D 21	1208
	31. DATE-FUED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE					
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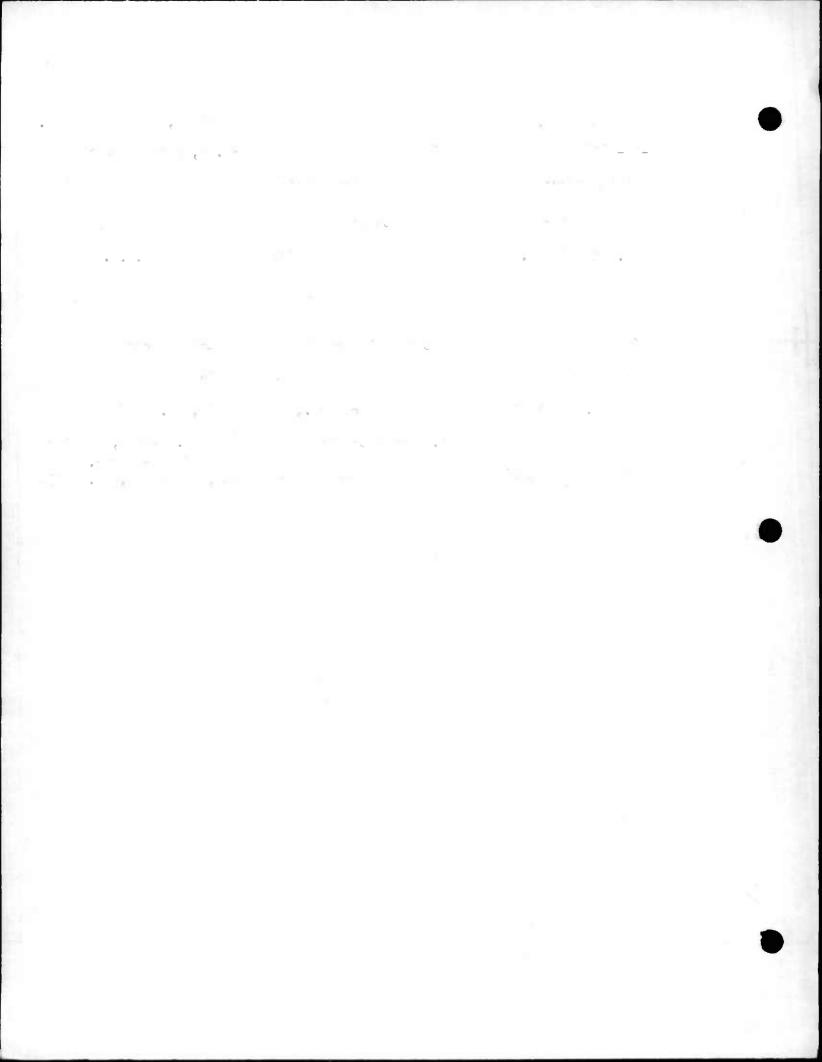
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely be filed within ZD hours after death with the State Dept. of Health and Memial Hyglene prior to burial, cremail IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, at
TO THE HOSPITAL OR TO THE FUNERAL DIR be filed within 72 hour IMPORTANT: If Iten

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 Agnes B. Crump April 8, 12:02 P.MM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign (Month, Day, Year) 220-38-0438 93 1 M 2 X F 1901 Maryland 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 14 Birch Avenue Glen Burnie Anne Arundel RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Allegany Maryland Cumberland 1 YES 2 NO FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 10 N. Liberty St. 21502 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—II yea, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES В 3 Widowed 4 Divorced White 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) econdary (0-12) College (1-4 or 5+) 6 Cafateria Worker County Schools once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Robert Graham 7 BE Agnes Rankin notified ; 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Margaret S. Albright 14 Birch Ave., Glen Burnie, Md. 21061 ě 2as. METHOD OF DISPOSITION
1-S Burlai 2 Cremellon 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must St. George Cemetery 4/11 Mt. Savage, Maryland 4 Donation 8 Other (Specify) medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 57 Frost Awe. Tos Durst Funeral Home, Frostburg, Md. 21532 23. PART J. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory strest, shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death traumatic event, the HEART FAILURE disease or condition resulting in death) 2 MOVIH. TO (OR AS A CONSEQUENCE OF):

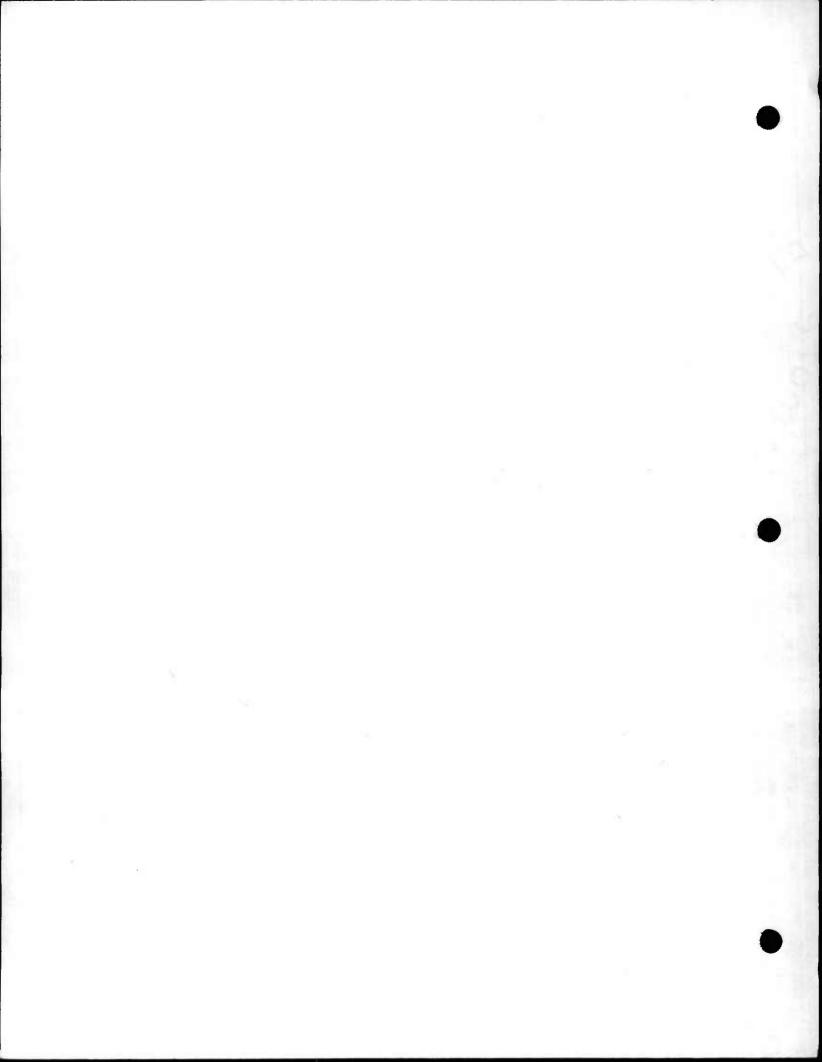
VERE HORMC STENDS/S CERTIFICATION Sequentially list conditions. if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in death) LAST 10 PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Resected PERFORMED? shows any 1 TYES 2 2000 ese 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🔊 UNCERTAIN 🗆 PHYSICIAN: Item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one, HOSPITAL: OTHER: 1 YES 2 NO OTHER:
4 □ Nursing Home 5 A Rasidence 8 □ Other (Specify) Inpatient 2 - ER/Outpatient 3 - DOA 10 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) marked, 28b. TIME OF 28c. INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Natural
Accident 5 Pending 1 YES 2 NO BY 3 Suicide 28e. PLACE OF INJURY — At home, larm, street, factory, office building, etc. (Specify) 28 is 28I. LOCATION (Street and Number or Rural Route Number, S Could not be determined COMPLETED 4 Homicide Item 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the ilme, date end place, and due to the cause(e) and manner ea stated. of axamination and/or investigation, in my opinion, death occured at the lime, date and place, and due to the cause(s) and manner se stated. BE 29c. LICENSE NUMBER 29d. DATE SIGNOD (Month, Day, Year) ENSING PHYSICIA 0298 0 2 -216ER 1406 S.CRAIN HWY # 106 GEN BURNIE 31. DATE FILED (Month, Day, 36. REGISTRAR'S SIGNATURE

14



	Panes	1	
) THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within whours after death. Page 6 may be retained by the hospital or attending physician.	) THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages	flee within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MODERATE IN House On to manufact on those of the same before an address from the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before the same before t
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亡	H C	1	John

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	1 - STATE REGISTRAR	STATE OF MARYLA		RTMENT OF		MENTAL HYGIEN REG. NO			
- 1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH D	AY Y	3. TIME OF DEA	ATH
	ANNA MARY C		vrs. (ast birthday)			APRIL 12	1999		
	219-46-0592  9a. FACILITY NAME (If not institution, give s	1□ M 2 💢 79	yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)  JULY 31 19	15	BIRTHPLACE (State or F Country)  MARYLAND	
<u>E</u>		an exerci			OR LOCATION OF E	DEATH		Y OF DEATH	
5	MORAN MANOR NURS			1000	ERNPORT		ALLI	EGANY	
DIRECTOR		LEGANY		STERNPO				10d. INSIDE CIT LIMITS? 11 YES 2	NO NO
FUNERAL	25701 shady lan	e S.W.			21562			N OF WHAT COUNTRY?	
B	11. MARITAL STATUS 1 Never Married 2 Married 2 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN L FORCES? 1 Tyes IF YES, OIVE WAR OR DATE	2 T NO	if yes, i	specify Cuban, Mexic ES 2 NO Speci	NIC ORIGIN? (Specify Yadian, Puerto Rican, etc.)	or No- 14	I. RACE — American Ind Black, White, atc. Specify:WHITE	llen,
TEI	15. DECEDENT'S EDUC (Specify only highest grade	CATION 1 completed)	(GIVE KING OF	USUAL OCCUPAT	TION nost of working	16b. KIND OF BU	SINESS/INOUS	TRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	HOUSE	KEEPER		HOUSE	KEEPI	€R	
BE CO	17. FATHER'S NAME (First, Middle, Last) ANDREW LEROY G	OODRICH			MALTIDE	AME (First, Middle, Malden E SNYDER			
5	19a. INFORMANT'S NAME (Type/Print) ANDREW LEE DAVIS		196. MAJLING	CINDY S	TREET CRO	OWLEY, TEXA	n, State, Zip Co S 7603	36-2907	
	20a. METHOD OF DISPOSITION    Marie   2   Cremetion 3   Remeted   Donation 5   Other (Specify)	oval from State 20b. P	SET CEM	OF DISPOSITION (I	Name of PRIL 14 1	1		y or Town, State  MARYLAND	
	21. SIGNATURE OF PUNERAL BERVICE LIC			22. NAME MERRI	AND ADDRESS OF FATT-ADAMS		ME		
	23. PART I. Enter the diseases, or d	omplications that caused t	he death. Do r	not enter the m	ode of dying, aud	ch as cerdiac or reapi	ratory arres	t, Approxim	neta
	IMMEDIATE CAUSE (Final	List only one cause on eec		~	1			interval B Onset an	od Dooth
	disease or condition reaulting in death)	Res	esperied	7 tow	line	· Pulmony		2 Ba	45
		DUE TO (OR AS A C	PHISEOUENCE OF	n:	75	. 00	2		1
VIION	if any, leading to immediate	DUE TO OR AS A C	ONSEQUENCE OF	P):	3 90000	10000	Kunda	~ 300	jens.
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A C	ONSEQUENCE OF	F):					
11	PART II. Other algnificent condition	a contribution to death but	not reculting	le the read-state		Section 1			
PHYSICIAN: MEDICAL		- Commenting to doctri but	not readiting	iii the underly)	ing cause given in	Part I. 24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY F AWAILABLE PRIOR COMPLETION OF OF DEATH?	OT F
≥	DID TOBACCO USE CONTR	RIBUTE TO CAUSE OF	DEATH YE	S D NO I	UNCERTAI	NAZ		1   YE\$ 2	NO
Ž I	25. WAS CASE REFERRED TO MEDICAL			TH (Check only one		11/84			
Sic	EXAMINER?	HOSPITAL: 1   Inpetient 2   ER/Outpeti	ent 3 DOA	OTHER:	me 5 🗆 Residence	6 Other (Specify)			
ВУ РН	27. MANNER OF DEATH  1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM INJ	E OF 28c. IN	JURY AT ORK? YES 2 NO	28d. OESCRIBE HOW II	NJURY OCCUR	EO	
	3 Suicide 6 Could not be determined	28s. PLACE OF INJURY — building, atc. (Specify)	At home, farm, s	streef, factory, offi	ca	261. LOCATION (Street a City or Town, State)	nd Number or	Rural Route Number,	
COMPLETED		CIAN: To the beat of my knowled						ause(s) and manner as a	stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU D 2124	MBER	29d. DATE SI	IONED (Month. Day, Year)	
요	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	1 (ITEM 27) (Tuna	Print)	D 2124		AI IV.	LW 13,1773	
		AN FROSTBURG			G, MARYL	AND 21532			
3	31. OATE FILEO (Month, Day, Year) APR 1 3 199	32. REGISTRAR'S SIGNATI					:		



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Myrtle M. Dennis 11:23 A M Apr. 15 4. SOCIAL SECURITY NUMBER 5 SEY 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH a. BIRTHPLACE (State or Foreign 01/03/1924 DAYS 1 M 2 F 217-12-4089 71 Maryland funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF CEATH 9c. COUNTY OF DEATH Deer's Head Center DIRECTOR Salisbury Wicomico RESIDENCE OF DECEDENT 10e STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Wicomico Eden 1 YES 2 NO FUNERAL 100 STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4101 Allen Road 21822 USA the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 W Married 1 TYES 2 X NO Specify: BY Specify: 3 Widowed 4 Divorced African American 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life, Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 7th laborer Domestic 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) te hours after death. Page 6 may be retained by Denwood Jones Cornelia Barkley BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Thomas A. Dennis same as above pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 1. Burlel 2 Cremation 3 Re 4 Donation 5 Other (Specify) Calvary Church Cernet. 4/20 Fruitland, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 1213 Jersey Road, Salisbury filled in by the fulion, or removal. Jolley Memorial Chapels - Maryland 21801 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not sntar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. 8 interval Betwe Onset and Death completely filled rial, cremation, o IMMEDIATE CAUSE (Final the disease or condition resulting in death) Nephropathy with End Stage Renal Disease 6yr. event. requires that the death certificate be executed with DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): n and com to burial, o Diabetes Type II 15 yr. traumatic CERTIFICATION Sequentisity list conditions DUE TO (OR AS A CONSEQUENCE OF):
Anemia of Chronic Disease attending physician a ental Hygiene prior to if sny, leading to immediate 8yr. cause. Enter UNDERLYING CAUSE (Disesse or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in desth) LAST 6 the atter PART II. Other significant conditions contributing to death but not resulting in the undariying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? signed by the Hypertension shows any 1 - YES 2 NO OF DEATH? 1 TYES 2 T NO t. of 1 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN has be Dept. HOSPITAL OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Lem this certificate h HOSPITAL: OTHER: 1 - YES 2 NO V□ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 8 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT WORK? 28b. TIME OF marked, 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending 1 YES 2 NO BY After 1 death 2 Accident 26s. PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify) 3 Suicide 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: A hours after d COMPLETED 6 Could not be 4 Homicide 29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 M 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE lama M.D. ConD haura A. 95 15 D33905 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) V.A. Dulany, M.D., CMD P.O. Box 2018 Salisbury MD 21801

32. PEGISTRAR'S SIGNATURED

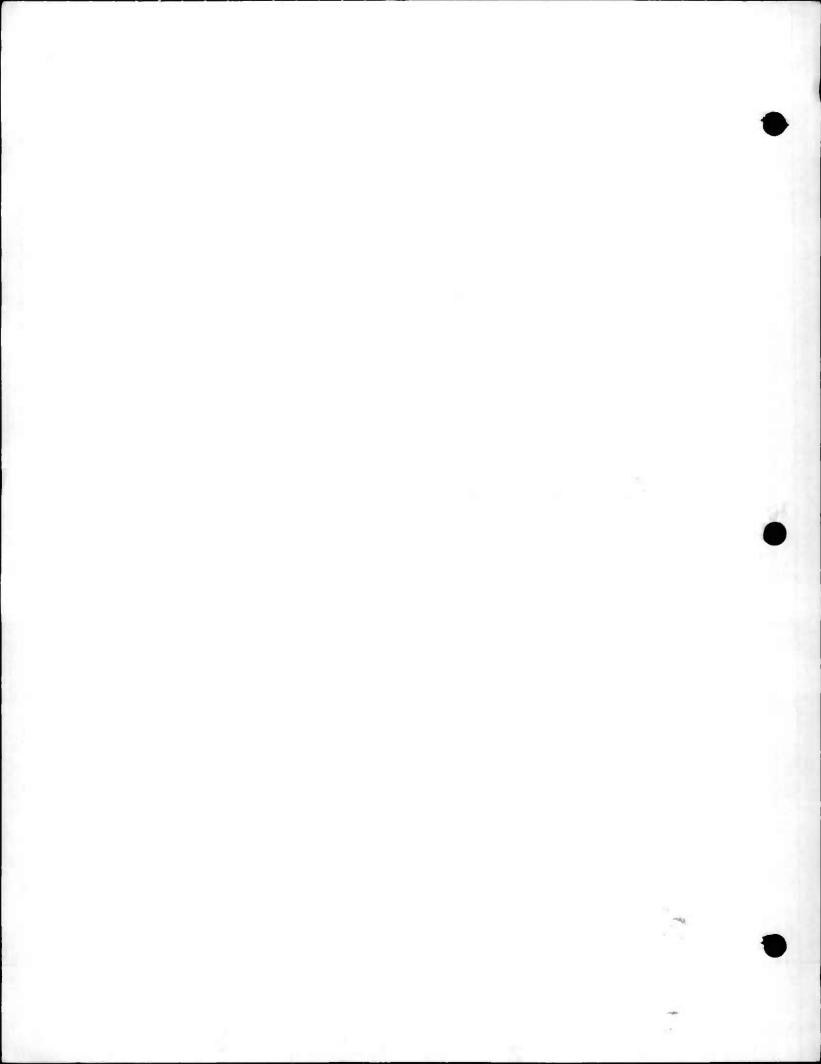
The Comment of

BALTIMORE, MARYLAND 21215-0020	INSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal,	IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO.

	REGISTRAR				CER	IIFIC	ALE OF	DEAL	н	RE	G. NO.			
	1. DECEDENT'S NAME (First, Mide	dle, Last)								2. DATE OF DE	ATH DA			3. TIME OF DEATH
1	Maria	nne	Bernice	Dar	niels				Δ	pril 7			YEAR	5:50 P M
	4. SOCIAL SECURITY NUMBER	T	5. SEX		yrs. last birth	viev) IF	UNDER 1 YEAR	IF UNDER		7. DATE OF BIF		. 7 7 3	a pier	HPLACE (State or Foreign
	215-82-1845	- 4	1 M 2 X F		24 ×	***	NTHE DAYS	HOURS	Barna	(Month, Day,	Year)	0=0	Coun	trv1
					24						, ,			nington, DC
_	9a. FACILITY NAME (If not instituti					9b	CITY, TOWN	OR LOCATIO	ON OF DEAT	ГН		9c. COL	INTY OF	DEATH
9	6922 St. Anne		venue			L	anham					Pri	nce	George's
DIRECTOR	RESIDENCE OF DECED													
1 2 1		COUNTY			104	c. CITY, TO	OWN OR LOCA	TION						10d. INSIDE CITY LIMITS?
	Maryland Pr	rince	e George	's		L	anham							1 YES 2 X NO
A	10e. STREET AND NUMBER						10	f. ZIP CODE				10g. CIT	IZEN OF	WHAT COUNTRY?
FUNERAL	6922 St. Anne	's Av	zenue =					20706	6			U.S	Α.	
3	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN	IIS ARMED		12 WAS DE			ORIGIN? (Spe	alfu Maa			C Asserted to
	1 Never Married 2 Marr	ied	FORCES? 1				If yes, a	pecify Cuban	n, Mexican,	Puerto Rican,	etc.)	01 NO-		E — American Indian, ik, White, etc.
B	3 Wildowed 4 Divorced		IF YES, GIVE V	MH OR DAI	ES		1   YE	2 X NO	Specify:				Spec	
0	15. DECEDEN	IT'S EDUC	ATION		16. DECEDE	WT'S LICE	IAL OCCUPAT	044	_	16b, KIND	05 8446			White
E	(Specify only high	nest grade o	completed)		(Give kir	nd of work HOT use rei	done during m	ost of working	g	TOD, KIND	OF BUS	HNESS/IN	DUSTRY	
1 2	Elementary/Secondary (0-12)		College (1-4 or 5					_		1				
COMPLETED					Legal	sec	retary	_			orn			
8	17. FATHER'S NAME (First, Middle,							18. MOTH	ER'S NAMI	E (First, Middle,	Maiden .	Sumame)		
l w l	William M.	Da	niels					Rit	ta V	. Wen	ze1			
8	19a. INFORMANT'S NAME (Type/P	rint)			19b. MA	ILING ADI	DRESS (Street	and Number	or Rural Ro	ute Number, City	or Town	n, State, Zi	(p Code)	
유	Rita V. Daniel	ls			692	2 St	. Anne	's Av	zenue	Lanh	am.	Mar	vlan	d 20706
	20a. METHOD OF DISPOSITION			20h I	_		ISPOSITION (N			DATE				
1	1 Buriel 2 Cremation 3 4 Donation 8 Other (Spec		vel from State	gume	tery, cremator	y or other p	placel	arrie or	1.100	VOE I	T T	AIION —	City or it	Virginia
	21. SIGNATURE OF FUNERAL SE		Chart	- 173	ropor	Itan	22, NAME A	atory	4/08	1/95 E	тех	andr	ria,	Virginia
1 1	-7//	#	DAUGE.	V		1					E.m	0 20 1	11	e, P.A.
	A tons	la	100	Da	sel									
$\neg$	23. PART I. Enter the diseer	ses or co	omniications the	t caused	the death	Do not	H/J/ I	ditti	lore	Ave, H	yat	LSV1	TIE.	MD 20781
	shock, or heart	fellure. L	lat only one ceu	SE OF SE	ch line.	DO HOL (	and the m	or dyli	ig, such	aa cerolac o	r reepii	ratory ar	Test,	Approximate Interval Between
1 1	IMMEDIATE CAUSE (Final													Onset and Death
	disease or condition resulting in death)		Dementi	a and	l Inar	iitio	on, Pr	ogres	sive					1 month
			DUE TO	(OR AS A	CONSEQUEN	CE OF):								
z	Localization		Late Sta	ige A	cquir	ed In	mmunod	efici	ency	Syndr	ome			4
일	Sequentially list conditions, if any, leading to immediate				CONSEQUEN									<u> </u>
CERTIFICATION	cause. Enter UNDERLYING													
畄	CAUSE (Disease or Injury that initiated events	6	DUE TO	(OR AS A C	CONSEQUEN	CE OF):							-	
토	resulting in deeth) LAST					,-								İ
핒		d.												
	PART II. Other algnificant co	onditiona	contributing to	deeth bu	t not reault	ling in th	ne underlyln	a cause a	Iven in Pa	ert I. 24a. V	MAS AN	AUTOPSY	248	. WERE AUTOPSY FINDINGS
IEDICAL							mossar.				PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
ā										_ 1 🗆	YES 2	₩ NO		OF DEATH?
Σ										_				1 YES 2 NO
														N/A
PHYSICIAN:	25. WAS CASE REFERRED TO ME						26. P	LACE OF DE	ATH (Check	only one)				
SS	EXAMINER? 1 ☐ YES 2 🔯 NO		HOSPITAL: 1   Inpatient 2	FR/Outnat	tiont 3 🗆 Di		HER:							
=	27. MANNER OF DEATH		28a, DATE OF			. TIME OF				Other (Spec				
	1 X Natural 5 Pend	ing	(Month, D	ay. Year)		INJURY	W	DUKS TA	/ 44			IJUHY OC	COMED	
B		tigation	N/			/ A		YES 2 🗌		N/A				
B	3 Suicide 6 Could		28e. PLACE O building,	FINJURY - etc. (Specify	— At home, for	erm, atree	t, factory, offic		2	81. LOCATION City or Town	(Street e.	nd Numbe	r or Rural	Route Number,
	4 Homicide deter	mined			N/A					N/A				
7	290. CERTIFIER 1 X CERTIFYIN	IG PHYSIC	IAN: To the best of	my knowle	doe death o	coursed at	the time det	and place	and due to	the enverter of			4-4	
COMPLET														e) end menner ee stated.
8						- g	y opinion,	A STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STATE OF THE STA	or the M	re, unte and pi	ace, and	a due to t	ne cause(	ero menner ee stated.
ш	29b. SIGNATURE AND TITLE OF C	ERTIFIER	10 10	D				29c. LICE	NSE NUMB	ER		29d. DAT	E SIGNED	(Month, Day, Year)
8	LOUIN	u M	EARN M	1/				D20	362			1	gori l	7 1995
욘	30. NAME AND ADDRESS OF PER	SON WHO	COMPLETED CAUS	SE OF DEAT	TH (ITEM 27)	(Type, Prin	e)					-	11/	-
0	Dr. Norton Els	on. 1	M.D. 652	5 Bel	Lcrest	Ros	ad. H ₁₇	atten	1110	Marri	land	1 20	0782	
	31. DATE FILED (Month, Day, Year)	,	32. REGISTRA	IS SIGNAT	TURE		, 11 y	uccs v		nary.	Lall	1 20	1104	
		1000	d.1.	the meters	w Rando	11								
	APR 10	JUUL	200.04.00.00	A REAL PROPERTY.										



BALTIMORE, MARYLAND 21215-0020	24 hours after death. Page 6 may be retained by the hospital or attending physician,	HE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 ed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020	HE MOSPTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	HE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fu ed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.	The same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa

	_	1 - STATE REGISTRAR	STATE OF MARYL			HEALTH AND I F DEATH	MENTAL HYGII REG. 1		
		1. DECEDENT'S NAME (First, Middle, Last)  ERIQUE &	PAVIS				2. DATE OF DEATH MONTH	DAY	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER 577-78-8/39	5. SEX 6. AGE (1)	In yrs. last birthday) 738 YRS.	IF UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year		D. BIRTHPLACE (State or Foreign Country)
pinons :	_	90. FACILITY NAME (If not institution, give	_	100		OR LOCATION OF OR		9c. COUNT	WASHINGON, D.C.
1, 2, 3	DIRECTOR	SETON HILL N			BART	TMORE, N	W.	BALT	TMORE CITY
ft. Pages	DIRE	D.C.	.TY		TY, TOWN OR LOC	CATION DIC	3		10d. INSIDE CITY LIMITS?  1 YES 2 NO
sit permit.	RAL	100. STREET AND NUMBER 2/5 R STRCZ	TINOW, W			2000/		10g. CITIZE	EN OF WHAT COUNTRY?
020 physiclan. burtal-transit	FUNERAL	11. MARITAL STATUS  1 Wester Merried 2 Merried	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS D	ECENDENT OF HISPAN specify Cuban, Mexice	IC ORIGIN? (Specify n, Puerto Ricen, etc.)	Yee or No — 1	4. RACE — American Indian, Black, While, etc.
21215-0020 al or attending physician, for use as the burial-trai	р Ву	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA		1 🗆 YI	ES 2 NO Specify			BLACK
21 al or for u	LETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)	College (1-4 or 5 +)	Ille. Do NOT u	work done during r se retired.)	most of working		BUSINESS/INDUS	
AND the hospital detached to	COMPLET	17. FATHER'S NAME (First, Middle, Lest)	2 yrs.	BUS DRI	VER-G	REYHOUND	ME (First, Middle, Maid		ATTON
2 2 2 Z	BE C	UNK	NOW			EMM	A DAVI	S Will	ians
i, MAR be retained ge 5 should e notified	5	190. INFORMANT'S NAME (Type/Print) Emma Davis		1023 S	ADORESS (Street	end Number or Rural F nael's Dr.	Mitchel	own, State, Zip C lville,	Md. 20721
		20e. METHOO OF DISPOSITION  1 1 Burlai 2 Cremetton 3 Ren 4 Donailon 5 Other (Specify)	noval from Stale come	PLACE AND DATE	OF DISPOSITION (	Name of	DATE 20c.	LOCATION — CII	y or Town, State
ALTIMOR death. Page 6 ma e funeral director, Id. examiner must		21. SIGNATURE OF FUNERAL SERVICE LI	ICENSEE	Armony N	22. NAME	AND ADDRESS OF FAC	CILITY	andover	
W - 5 - 9		Dama	whall	<u> </u>	Marsh 4217	9th. St.	neral Hom N.W. Was	e nington	, D.C. 20011
d in b		23. PART I. Entertha diseases, or ahock, or heart fallure.  IMMEDIATE CAUSE (Final	complications that caused. List only one cause on ea	the death. Do inch line.	not anter the m	noda of dylng, aucl	as cardiac or re	spiratory arrea	at, Approximate Interval Between Onset and Death
760, ad withir 24 in ompletely filled I, cremation, event, the		disease or condition resulting in death)	a. Acquie	set Im	mune	Deficien	cy Syn	deone	
B 2 - 2	NO	Sequentially list conditions,	b			*	,		0
BOX 68 cate be execut hysician and c prior to burit r traumatic	CATI	If any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO (OR AS A	CONSEQUENCE OF	F):				
certification of the Hyglene	CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE O	F):				
DS, F the death the atter d Mental injury, o	- 1	PART II. Other aignificant condition	na contributing to death bu	ut not reaulting	in the underlyi	ng cause given in	Part I. 24a, WAS	AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
any any	DICAL						PERF	2 NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
L REC law requires as been sign lept, of Heal 23 shows	N: MED	DID TOBACCO USE CONT	RIBUTE TO CAUSE OF	F DEATH YE	S 🗆 NO [	☐ UNCERTAIN			1 - YES 2 NO
- 62 64	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT					
OF VITA PHYSICIAN: The this certificate h with the State C	PHYS	1 U YES 2 NO 27. MANNER OF DEATH	1 Inpetient 2 ER/Outpe	28b. TIM	E OF 28c. IN	ome 5 Realdence	8 Other (Specify) 28d. DESCRIBE HOV	V INJURY OCCU	RED
日 年 聖 多 名	BY	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)  28e. PLACE OF INJURY		M 1	VORK? YES 2 NO			
OIVISIO OR ATTENO DIRECTOR: A hours after d	ETED	3 Suicide 8 Could not be 4 Homicide determined	building, atc. (Specia	ify)	intees, sectory, on	ice	281. LOCATION (Stre- City or Town, Sta		Rural Route Number,
로 크인 느	COMPLET	one) 2 MEDICAL EXAMINI	SICIAN: To the best of my knowle ER: On the beele of examination						
TO THE HOSPIT TO THE FUNERA be filed within 7	TO BE	296. SIGNATURE AND TITLE OF CERTIFIE	M) atten	ding of	hysician	29c. LICENSE NUM	BER S	29d. DATE \$	IGNED (Month, Day, Year)
		30. NAME AND ADDRESS OF PERSON WITH	Khy 82	IN EU	tow S	+, suite 4	107, Ba	Himore	MD 21201.
		ADD (10 1005	32. REGISTRAR'S SIGNA	N.					

the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within exclinations after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

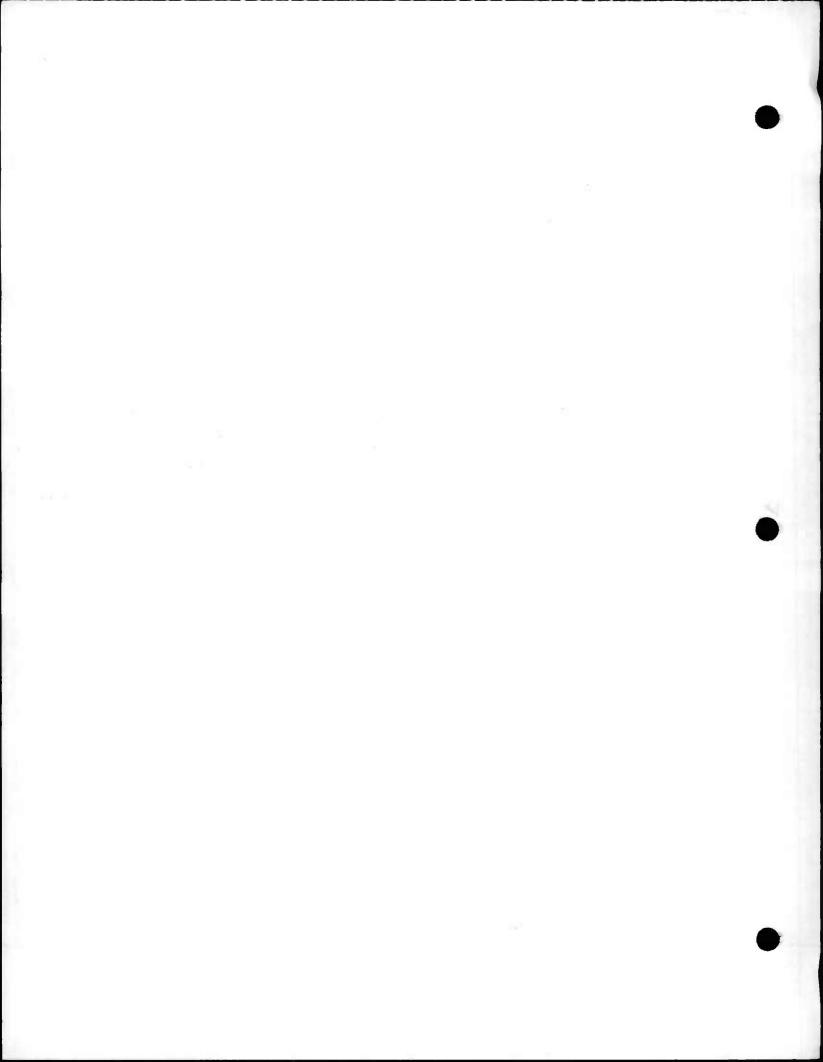
FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL	HYGIENE REG. NO.
DECEOENT'S NAME (First, Middle, Last)		2. DATE O	F DEATN

	1. DECEOENT'S NAME (First				OLITT	II IQA	I L OI	DLA	111	HE	G. NO.			
,										2. DATE OF DE MONTH	DAY	,	YEAR	3. TIME OF DEATN
	Mary Ma		D'Amat	0						April	11,	. 19	995	4:15 P M
1	4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (In	yrs. last birtho		DER 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIF	нтн		8. BIRTI	IPLACE (State or Foreign
	579-01-6.	549	1 🗆 M 2 😾 F	9	2 YR	S. MONTH	B DAYS	HOURS	MIN.	Month, Day,	8 1	902	Count	York
1	9a. FACILITY NAME (If not in	nstitution, aive «	treet and number			95.0	TV TOWN	OR LOCATE	ON OF DEAT		- , _		NTY OF D	
œ I	the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract of the contract o								ON OF DEA	ın	1			
DIRECTOR	Presidentia		ds Nursi	ng Hor	me	A	delph	11				Pri	nce (	George's
ပ္ပ	10a. STATE	10b. COUNTY	,			CITY, TOW								
三月	(1986)			,	100.									10d. INSIDE CITY LIMITS?
۹.	Maryland		ce George	2 ' S		H	yatts	ville	2					1 🔀 YES 2 🗌 NO
BY FUNERAL	10a. STREET AND NUMBER						-1	of. ZIP COD	E			10g. CIT	IZEN OF	VHAT COUNTRY?
۵ II	1801 Metzei	rott Ro	oad					20783	3			U.S	S.A.	
3	11. MARITAL STATUS		12. WAS DECEDEN	IT EVER IN U	J.S. ARMED	1	3. WAS DE	CENDENT O	F HISPANIC	ORIGIN7 (Spe	city Year	or No.	14 PACI	- American Indian,
<u> </u>	1 Never Married 2	Married	FORCES? 1			- 1	If yes, s	pecify Cuba	n, Maxican,	Puerto Rican,	atc.)		Black	t, White, atc.
<u>6</u>	3 🔯 Widowed 4 🗌 Divo	orced	IF TES, GIVE V	WHI OH DAIL	ES		1 [] YE	S 2 🙀 NO	Specify:				Speci	caucasian
۵ ا	15. DEC	EDENT'S EDU	CATION	1	6a. DECEDEN	T'S HSHAL	OCCUPAT	ION		Tage Man	05 01101			Caucastan
	(Specify onl	y highest grade	completed)		(Give kind		ne during m	ost of workir	g	16b. KIND	OF BUSI	MESS/INL	DUSTRY	
ון ב	Elementary/Secondary (0	0-12)	College (1-4 or 5	+)						II C	Co			
<u> </u>					Clerk	тур.	ısı			0.5	• 60	veri	nment	
COMPLETED	17. FATHER'S NAME (First, M							18. MOTI	HER'S NAME	E (First, Middle,	Maiden S	iumame)		
BE	Steven Be	ednarch	nak					A	ına `	Yuhas				
	19a. INFORMANT'S NAME (	Type/Print)			19b. MAIL	ING ADORE	ESS (Street	and Number	or Rural Rou	ute Number, City	y or Town,	State, Zip	Code)	
임	Robert D'An	nato								dale,				737
	20a, METNOD OF DISPOSIT	ION		20h B	LACE AND DA								City or To	
	1 N Burlat 2 Crematic		oval from Stata	cemete	ery, cremetory Surrec	or other place	Ce)	terne or	/ /1	1				
	4 Donation 5 Other  21. SIGNATURE OF FUNERA		ENGER	_ Kes	surrec						Clin	ton,	, Mai	ryland
	21. SIGNAL DIE OF PUNERA	SERVICE LIC	ENSEE						SS OF FACIL		E	1	TT	D 4
	h h i · i ·	5.6												ne, P.A.
	23. PART I. Enter the d	leases or o	and adjace the	1	h . 4		+/39	Balt	Lmore	Ave.,	нуас	tsvi	ille,	MD 20781
- 1	ahock, or h	eart fellure.	List only one ceu	se on eac	h line.	o not ant	er the m	oda or dyi	ng, auch a	as cardiec o	r respira	atory an	rest,	Approximata Interval Between
	IMMEDIATE CAUSE (FIR	nal	OAR	10	D									Onset and Deeth
	disease or condition	<b>→</b>	CARD				TOR	y r	AILU	IRE				
- 1			DUE TO	(OR AS A C	ONSEQUENC	E OF):	00							
z			PSEU	20-	BOLL	EL I	YBS	TRU	CTIC	ON				2+ MONTA
ੁ∥	Sequentially list condit if any, leading to imma		DUE TO	(OR AS A C	ONSEQUENC	OD.								2 10/1/17
₹	ceuse. Enter UNDERLY	ING		(F1	4STR	ic	OUT	LET	- )					
	CAUSE (Disease or Injuthat Initiated events	iry S	~		ONSEQUENC				<del>-</del> -					
ERTIFICATION	resulting in death) LAS	T				, .								
												-		
- 19	PART II. Other algnifica	nt condition	s contributing to	deeth but	not resulti	ng in tha	underivir	ng cause o	ilven in Pa	ort 1. 24n 3	MAS AN A	UTOPSY	245	WERE AUTOPSY FINDINGS
5	ATR	CIAL F	FIBRILLI	ATIDA	VID	LABE	TES	MI	-1117	710	PERFORM		1 240	AVAILABLE PRIOR TO
EDICAL		OFE	1111	115	241			1/2	24/1	1_	YES 2	XNO .	-	DF DEATH?
ž∥			HIATAL							_				1 TYES 2 TO NO
ž	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF	DEATH	YES 🗆	NO [	JUNC	ERTAIN					
<u> </u>	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL		26.	PLACE OF	EATH (Chec	ck only one	)			_			
HYSICIAN:	1 TES 2 NO		HOSPITAL:	ER/Outpati	ent 3 🗆 DO	QTHI 4 M N		ne 5 🗆 Re	aldence 8	Other (Spec	46.0			
Ì	27. MANNER OF DEATH		28a. OATE OF			TIME OF	_	JURY AT		8d. DESCRIBE		ILIBY OC	CURED	
-		Pending	(Month, D			INJURY	W	YES 2		ou. DESCRIBE	NOW IN	JOH! OCI	CORED	
6	Pacificant	Investigation	20- 51 405 0	F 101 11 1801					37					
3		Could not be determined	28e. PLACE O building,	etc. (Specify)	At home, far	m, atreet, fa	actory, offi	Ca	2	8f. LOCATION City or Town	(Street and r. State)	d Number	or Rural F	oute Number,
7	29a. CERTIFIER (Check only	IFYING PHYSIC	CIAN: To the best of	my knowled	iga, death occ	urred at the	e time, dat	and place.	and dua to	the causals) s	nd mann	or as stat	ed.	
COMPL														and manner as stated.
						-,		_			ove, and	200 tO th	- causals	with memier as stated.
<b>8</b>	29b. SIGNATURE AND TITLE	OF CERTIFIER	Made.	Naus	elw	M	7		NSE NUMBE		T	29d. OATI	E SIGNED	(Month, Day, Year)
3 II.			Marie (	A		1-1-7		D	212	74			4/11	195 -
- [	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	SE OF OEATH	N (FEM 27)	ype, Print)		- n	4.3	1	0.0		1	
	30. NAME AND ADDRESS OF ABDUL	VAYE	EMM.D	, 345	10.10	RTM	TEAL	X KO	AD,	LAUF	KEL	- , ^	7 D.	20724
	31. DATE FILEO (Month, Day,		32. REGISTRA											
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	3	4. SOCIAL SECURITY NUME 716-07-0252	BER	5. SEX 14 M 2 D F	6. AGE	(In yrs. last birtl	· ·	IF UNDER	1 YEAR DAYS	IF UNDER	R 24 HRS.	7. DATE	ог віятн 5 ^{раў.} 190	T a		ACE (State or Formion
3 should		9a. FACILITY NAME (If not in	nstitution, give s			· ·		9b. CITY	, TOWN (	OR LOCATI	ION OF DE		3, 190	9c. COUNT		
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STOR:	9	4 Homicide	Could not be determined	28e. PLACE Of building,	etc. (Spec	— At home, fe	erm, str	reet, fecto	ory, oHice	•		28f. LOC City	ATION (Street a or Town, State)	nd Number or	Rural Route	n Number,
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288	임	30. NAME AND ADDRESS OF Dr. Jesus T	PERSON WHO	completed caus	Plaz	ATH (ITEM 27)	Östi	ourg	, MI		1532	۲۷		- 4	1181	70
6		31. DATE FILED (Month, Day, 1	0 100	AZ GEGISTRA	R'S GIGN	atua del	4			-						



DIVISION OF VITAL RECORDS, P.O. BOX 68760 SALTIMORE, MARYLAND 21215-0020	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Chours after death. Page 6 may be retained by the hospital or attending physici	DISCOME After the horse almost the the state absent the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s
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page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should ending physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the flow of the death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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	1 - FOR STATE REGISTRAR	STATE OF MA	ARYLAND /	DEPAR	TMENT OF	HEALTH DEAT	AND I	MENTA	L HYGIE				
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE	OF DEATH			3. TIME OF	DEATH
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	4. SOCIAL SECURITY NUMBER	723212	. AGE (In yrs. last	birthday)	IF UNDER 1 YEAR	IF UNDER	24 HRS.		OF BIRTH	, 195		HPLACE (State	A
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	9s. FACILITY NAME (If not institution, give stre		03		9b. CITY, TOWN	27.120.77			8, 1			ryland	
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6	1665 Shookstown F	Koad			Fred	erick				F	rede	rick	
DIRECTOR	10e. STATE 10b. COUNTY			10c. CITY	, TOWH OR LOCA	TION						10d. INSIDE	CITY
#	Maryland Frede	rick			Frede	a 4 a 1-						LIMITS:	
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	21. SIGNATURE OF FUNERAL SERVICE LIDE	HSEE ()			22. NAME A	ND ADDRES	S OF FAC	CILITY S t	auffe	r Fu	nera:	l Home	s, P.A
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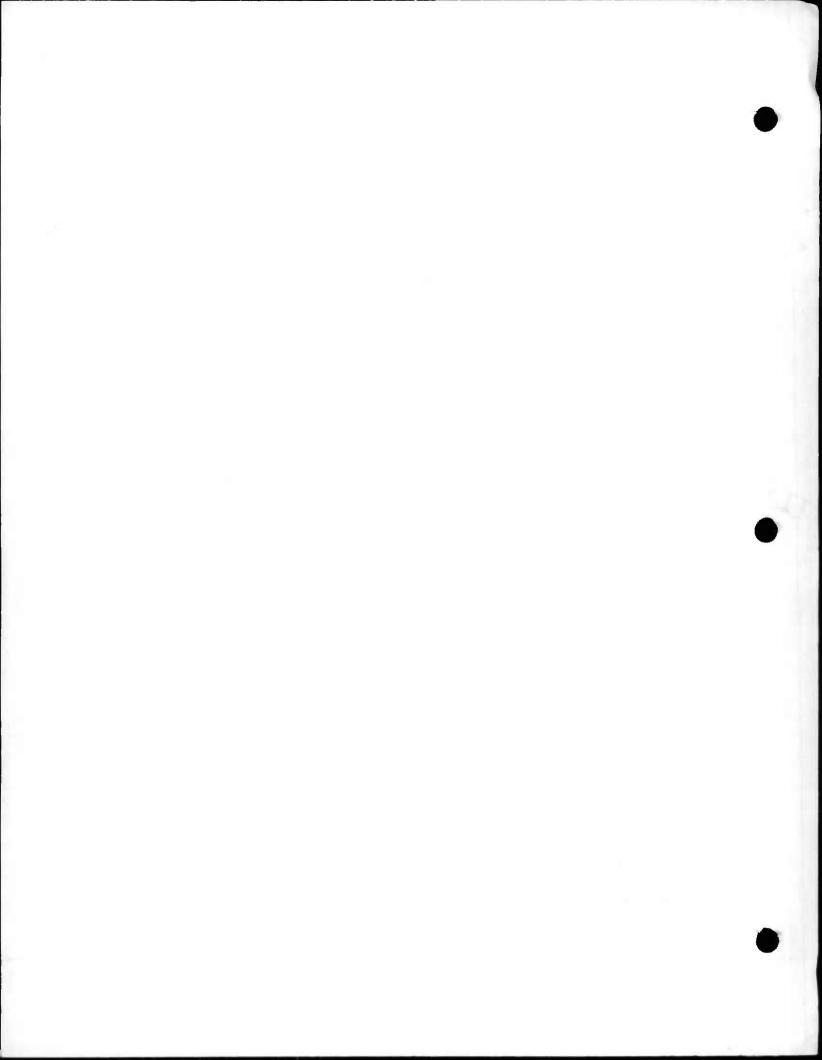
310 West Ninth Street Frederick, Maryland

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M.D.

32. REDISTRAR'S SIGNATURE
Julia d'Audion Ravialle

Dr. Kusay Barakat, 31. DATE FILED (Month, Day, Year) APR 2 1 1995



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Degr. or Hearth and Mental Hygher prior to burial, cremation, or removal.

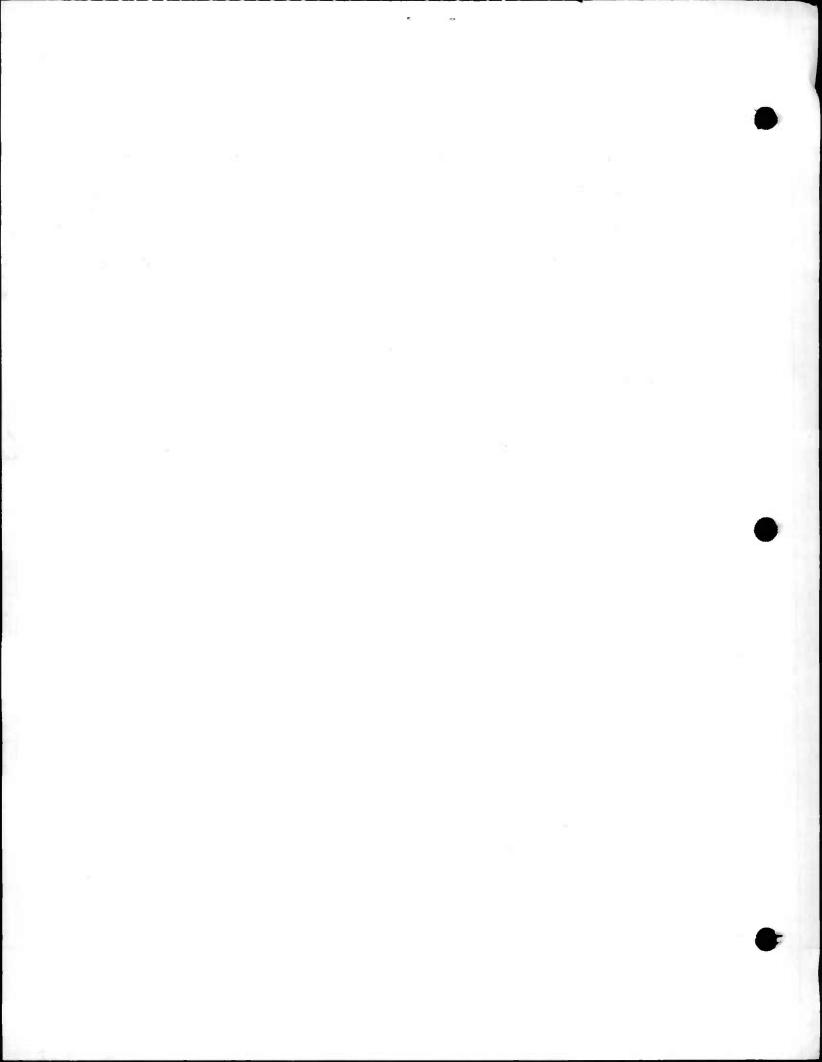
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		FOR STATE REGISTRAR		STATE OF I	MARYLANI	D / DEPAR	RTMENT	T OF H	EALTH DEA	AND I		YGIEN EG. NO.	E		
		1. DECEDENT'S NAME (First	t, Middle, Last)								2. DATE OF D	EATN			3. TIME OF DEATH
		Eua							April	2	19	95	5:00p M		
- }		4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (In yrs	s. lest birthday)	IF UNDER	I YEAR	IF UNDER	24 HRS.	7 DATE OF B	ISTN		S BIRTI	IPI ACE (State or Foreign
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	5	Maryland	H _C	ward			olum	bia							LIMITS?
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	3	10799 Hickory Ridge Road 21044 United States													
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	2	19a. INFORMANT'S NAME (Type/Print)  19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
9		Pat Shaffer				88 La	ike V	iew	Terr	ace	Hanov	er,	Penn	sylv	ania 17331
15	- 1	20a. METNOD OF DISPOSIT  1  Burlel 2 Cremetic	on 3 🗆 Rem	iqual from State ,	20b. PLA	CEAND DATE	OF DISPOS	SITION (Na	ma of		DATE		CATION -		
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exa	ļ	Alan	1	70	0000	//									City 21043
		23. PART i. Enter the d	liseeeds pr	complications the	et caused the	death Do	ont enter	the mo	do of du	COTO	minta P	Tre	DTTT	.0000	
medicai		23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between													
2	1	IMMEDIATE CAUSE (Fir disease or condition	nal /		1	/ /	T		//_	1.					Onset and Death
Ę	ŀ	resulting in deeth)	→	· Byo	< ard	16	-10	1 7	6.00	110,	5				1 hour
8				DUE TO	(OR AS A COR	NSEQUENCE O	F):								
other traumatic event, the	ERTIFICATION	Sequentially list condit	lone.	b											
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2	5	CAUSE (Disease or inju		C											
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E .	ਹੇ	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:	26. P	LACE OF DEA	TH (Check			,					
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Ĕ	<u>~</u>		Pending Investigation				М		ES 2	NO					
92	ا ۵	3 D Sulates —	Could not be	28e, PLACE C	F INJURY — A	t home, term,	atreet, lect	ory, office			281. LOCATION	(Street a	nd Number	or Rural I	Route Number,
00	ш	4 Nomicide determined City or Town, State)													
E .	COMPLET	29a. CERTIFIER (Check only)  CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and menner as stated.													
=	١١	(Check only one)  2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.									) and manner or stated				
AN		296. SIGNATURE AND TITLE			7	Julyana	,, 0	,				riaud, alk	a due to th	re cense(s	o, end manner 80 slated.
APORTANT: II	W	STATE AND OTHE	y canting	1	//					ENSE NUN	4BER		29d. DAT	E SIGNED	(Month, Day, Year)
E		- A L		. 1 1000	# .			- 1	/1	22	c - L-	<i>)</i> I		11/	01//04

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM, 27) (Type, Print)

31. DATE FILED (Month, Day, Year)

PREGISTRAR'S SIGNATURE
Shouldon Roydall

Colum Gia



	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within F.Y. hours after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache		IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	NG	fter	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ша
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	FOR		STATE OF A	ARYI AND	/ DEPAR	TMENT	UE H	EALTH AND	MENTA	LUVCIEN	E			
	1 - STATE REGISTRAR		- OINTE OF T	C	ERTIF	ICATE	OF	DEATH	MENIA	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)  2. DATE OF DEATH MONTH  THOMAC DEATH AND DAVID C								H DA	199	YEAR	5:45 A M		
	4. SOCIAL SECURITY NUMBER 219-16-2256		5. SEX 1 M 2 D F	8. AGE (In yrs. I	last birthday) YRS.	IF UNDER 1	YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE	OF BIRTH h, Day, Year)		B. BIRTHPI	LACE (State or Foreign	
	Sa. FACILITY NAME (If not in	86	00			R LOCATION OF D	Nov	November30,1			908 Maryland			
OR	Fort Wash	ningt		cal Ce	l Center Fort Washi							George		
<u>E</u>	RESIDENCE OF DEC	10b. COUNT			10c. CITY, TOWN OR LOCATION									
DIR	Maryland	Chai	rles		Indian Head						- 1	IOd. INSIDE CITY LIMITS?  YES 2 NO		
3AL	10e. STREET AND NUMBER	Street					101.	ZIP CODE			EN OF WH	AT COUNTRY?		
NE						20640		U						
TO BE COMPLETED BY FUNERAL DIRECTOR	11. MARITAL STATUS  1 Never Merried  2 Married  1 Never Merried  3 Widowed 4 Divorced			YES 2	YES 2 X NO			13. WAS DECENDENT OF HISPANIC ORIGIN?  If yes, specify Cuban, Mexican, Puerto Ri  1 ☐ YES 2 ☒ ☒O Specify:				Specify Yea or No— an, etc.)  14. RACE — Black, W Specify:		
		Sec. 131 - 204-100			1						White			
	15. DEC (Specify only	16a. C	(Give kind of work done during most of working life. Do NOT use retired.) Lab. Tech.				168	. KIND OF BUS	INESS/INDU	STRY				
	Elementary/Secondary (0	Re	Research & Developement						. Got	ern	ment			
	17. FATHER'S NAME (First, M							AME (First, Middle, Malden Surname)						
	Bradford		Davis					- 1 - 1 - 1			Pose	4		
	19a. INFORMANT'S NAME (7			1				d Number or Rural	Route Num	ber, City or Town	, State, Zip C	lode)		
	Virginia N			1.00		ne as								
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	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY									aryland				
	121-1		Williams Funeral Home, P.A.											
	23. PART i. Enter the di	bassada or o	complications that	MI MI	00668	Rt	. 2	225 & 0	G1ym	ont Ro	d., I	ndi	an Head, N	
	23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, abock, or heart feliure. List only one ceuse on each line.  Approximate interval Between													
	disease or condition													
VIION	resulting in death) . Gastrointestinal hemorrhage 12 hour													
	Sequentially list conditi													
	ii arry, leading to immediate											2 days		
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FICATIO	If any, leading to immed cause. Enter UNDERLY! CAUSE (Disease or Inju	NG	с	OR AS A CONSI									2 days	
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